

Burton vs Dr. Partha Ghosh and Wexford Health Sources, Inc.

12 CV 8443

Deposition of: Chadwick Prodromos, M.D.

Taken on: January 04, 2018

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1 IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN
2 DISTRICT OF ILLINOIS, EASTERN DIVISION

3 ALNORAINDUS BURTON,)
4)
5 Plaintiff,)
6) No. 12 CV 08443
7 -vs-)
8 DR. PARTHA GHOSH and)
9 WEXFORD HEALTH SOURCES,)
10 INC.,)
11 Defendants.)

12 The deposition of CHADWICK PRODROMOS, M.D.,
13 called for examination, taken pursuant to the Federal
14 Rules of Civil Procedure of the United States District
15 Courts pertaining to the taking of depositions, taken
16 before KAREN ORENSTEIN, CSR No. 84-4693, a Certified
17 Shorthand Reporter of the State of Illinois, and a
18 Registered Professional Reporter, at
19 1714 Milwaukee Avenue, Glenview, Illinois, on
20 January 4, 2018, commencing at 4:26 p.m.

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1 PRESENT:		1 THE VIDEOGRAPHER: We are now on the record for the
2		2 video deposition of Dr. Chadwick Prodromos. Today's
3 KIRKLAND & ELLIS		3 date is January 4, 2018, and the time is 4:26 p.m.
4 MR. WILLIAM O'HARA		4 I am a legal video specialist with Jensen
5 MR. HOWARD M. KAPLAN		5 Litigation Solutions.
6 300 North LaSalle Street		6 Will Counsel please identify themselves and
7 Suite 2400,		7 whom they represent.
8 Chicago, Illinois 60654		8 MR. O'HARA: This is William O'Hara from Kirkland &
9 Phone: (312) 861-2000		9 Ellis. We represent the plaintiff, Alnoraindus Burton.
10 E-mail: william.ohara@kirkland.com		10 MR. KAPLAN: Howard Kaplan also for the plaintiff.
11 howard.kaplan@kirkland.com		11 MR. LOMBARDO: Joe Lombardo on behalf of the
12		12 defendants.
13 On behalf of the Plaintiff;		13 THE VIDEOGRAPHER: The court reporter today is here
14 CASSIDAY SCHADE		14 on behalf of Jensen Litigation Solutions.
15 MR. JOSEPH J. LOMBARDO		15 Please swear in the witness.
16 20 North Wacker Drive		16 (WHEREUPON, the witness
17 Suite 1000		17 was duly sworn.)
18 Chicago, Illinois 60606		18 CHADWICK PRODROMOS, M.D.,
19 Phone: (312) 641-3100		19 called as a witness herein, having been first duly
20 E-mail: jlombardo@cassiday.com		20 sworn, was examined and testified as follows:
21		21 EXAMINATION
22 On behalf of the Defendants.		22 BY MR. O'HARA:
23 ALSO PRESENT: Mr. James Porter (videographer).		23 Q. Dr. Prodromos, thanks for taking the time to
24 REPORTED BY: KAREN ORENSTEIN, CSR, RPR, CSR Certificate No. 84-4693		24 meet with us today. I know you are very busy. As I
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1 I N D E X		1 said, my name is William O'Hara. I'm with the law firm
2 WITNESS NAME	EXAMINATION	2 of Kirkland & Ellis. This is my colleague, Howard
3 CHADWICK PRODROMOS, M.D.	PAGE	3 Kaplan. We represent the plaintiff, Mr. Burton, in the
4 By Mr. O'Hara	4, 157	4 Burton v. Ghosh matter. As you know, this deposition is
5 By Mr. Lombardo	150	5 being videotaped and the court reporter is creating a
6		6 written record.
7 E X H I B I T S		7 You have been deposed before; is that correct?
8 DEPOSITION EXHIBIT	MARKED FOR ID	8 A. Yes.
9 No. 1	6	9 Q. About how many times?
10 No. 2	30	10 A. Oh, in 32 years of practice, maybe under 200.
11 No. 3	67	11 Couple hundred, maybe.
12 No. 4	113	12 Q. So you are familiar with the procedures?
13		13 A. Yeah.
14		14 Q. I will go through the ground rules as a
15		15 refresher. Please answer all my questions verbally and
16		16 not with physical movements like a nod or shrug. Even
17		17 though there is a video, we want all your answers
18		18 reflected on the written transcript as well.
19		19 Please do wait until I've completed my
20		20 question before answering. And if you do need to have a
21		21 question repeated, please let me know and the court
22		22 reporter can read it back to you.
23		23 Please also let me know if you don't
24		24 understand a question or if you need me to rephrase it.

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<p>1 If you go ahead and answer a question, I'm going to 2 assume that you understood it. And please let me know 3 if you need a break at any point except I'd ask that you 4 not do so while a question is pending.</p> <p>5 Could you please state your full name for the 6 record.</p> <p>7 A. Chadwick C. Prodromos.</p> <p>8 MR. O'HARA: Can I get the first exhibit there?</p> <p>9 BY MR. O'HARA:</p> <p>10 Q. So I'm holding what is titled Defendants' 11 Rule 26(a)(2) disclosure. It is the disclosures that 12 your law firm sent over ahead of this deposition. We 13 added Bates stamps to it that are marked BUR1 14 through 17. I'm marking this as Plaintiff's Exhibit 1.</p> <p>15 (WHEREUPON, a certain document was 16 marked Plaintiff's Deposition 17 Exhibit No. 1, for identification, 18 as of 01/04/2018.)</p> <p>19 BY MR. O'HARA:</p> <p>20 Q. Do you recognize this document, Dr. Prodromos?</p> <p>21 A. Yes.</p> <p>22 Q. Great.</p> <p>23 So it consists of a cover letter with 24 disclosures and then a part A, which is your report, and</p>	<p>1 this document?</p> <p>2 A. As I said, there may be a couple of 3 presentations here and there, but this is most 4 everything.</p> <p>5 Q. Could you explain what the subject of those 6 presentations might have been about?</p> <p>7 A. Well, I did one in Lyon, France, where I was 8 the moderator for the European Sports Medicine Society, 9 International Sports Medicine Society on cartilage 10 damage in people with ACL reconstructions. So that was 11 2016. And it looks like -- oh, no, that's in there, 12 '15. So, yeah, that one. I don't think there have been 13 any major ones since then that I can think of.</p> <p>14 Q. Okay. We may ask afterwards if you remember 15 and come up with any, to send us those.</p> <p>16 We'll briefly just walk through your education 17 if that's all right.</p> <p>18 A. Sure.</p> <p>19 Q. You did your undergrad study at Princeton; is 20 that correct?</p> <p>21 A. Yes.</p> <p>22 Q. What was your major there?</p> <p>23 A. My major was biology and I have a certificate 24 in science and human affairs, but biology.</p>
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<p>1 a part B, which is your CV; is that correct?</p> <p>2 A. Yes.</p> <p>3 Q. Great. Thank you.</p> <p>4 Can we turn to part B, your CV?</p> <p>5 A. Yes.</p> <p>6 Q. Did you draft this CV yourself?</p> <p>7 A. Pretty much.</p> <p>8 Q. When did you last update this document?</p> <p>9 A. Well, let me see. It was partially updated to 10 get the second edition of my ACL textbook this year. I 11 think there were a few papers since '15, presentations 12 that probably aren't in here, but...</p> <p>13 Q. Okay. We'll get at that.</p> <p>14 Is all the information that's in the CV 15 accurate to your knowledge?</p> <p>16 A. Yes.</p> <p>17 Q. Is this a complete representation of your 18 educational and professional background?</p> <p>19 A. Yes.</p> <p>20 Q. That was my next question. Is there any 21 information you didn't include?</p> <p>22 A. No.</p> <p>23 Q. Is there any new information about your 24 education, experience, or publications since you drafted</p>	<p>1 Q. And when did you graduate from Princeton?</p> <p>2 A. '75.</p> <p>3 Q. And what was the degree you earned there, a 4 B.S.?</p> <p>5 A. Everybody there gets a bachelor's of arts 6 unless you are an engineer, so A.B.</p> <p>7 Q. That's right.</p> <p>8 A. Art baccalaureate.</p> <p>9 Q. And did you go immediately to undergraduate 10 school from Princeton?</p> <p>11 A. I did.</p> <p>12 Q. And where did you go to graduate school?</p> <p>13 A. At Johns Hopkins Medical School.</p> <p>14 Q. What was your area of focus there?</p> <p>15 A. There isn't one. You just get an M.D. It's 16 the same for everybody.</p> <p>17 Q. So you graduated with an M.D.?</p> <p>18 A. Yes.</p> <p>19 Q. And what year did you graduate from Johns 20 Hopkins?</p> <p>21 A. '79.</p> <p>22 Q. And what did you do after graduating from 23 Johns Hopkins?</p> <p>24 A. I did an internship at the University of</p>

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<p>1 Chicago. It's kind of a rotating surgical internship 2 for a year.</p> <p>3 Q. Were there any gaps in your education?</p> <p>4 A. No.</p> <p>5 Q. And you are also board-certified in orthopedic surgery; is that right?</p> <p>6 A. Yes.</p> <p>7 Q. What does that mean, briefly?</p> <p>8 A. Board certification means that you pass 9 examinations of one sort or another that attests to your 10 having a level of knowledge, I guess, knowledge and 11 competence, maybe, in a given field.</p> <p>12 Q. And when did you receive your board certification?</p> <p>13 A. Initially in '87. You are required to wait 14 two years before you take it. So I took it at the first 15 available time in '87. It's been every ten years since 16 then. Just did it again in 2016. You can do it a year 17 earlier to get it out of the way.</p> <p>18 Q. What are the requirements?</p> <p>19 A. Well, initially you have to complete a 20 residency. And I'm trying to remember. You have to 21 submit cases. You have an oral exam. I think, a 22 written exam. So the initial one is kind of a big</p>	<p>Page 10</p> <p>1 fellowship for a year at the Harvard Medical School and 2 Massachusetts General Hospital in orthopedic surgery in 3 sports medicine.</p> <p>4 Q. And after Mass General?</p> <p>5 A. Then I came back here and have been in private 6 practice ever since.</p> <p>7 Q. Terrific.</p> <p>8 When did you begin working here at Illinois Sports Medicine?</p> <p>9 A. Like shortly after I finished. So I finished 10 in -- My first day in practice was August of '85. And 11 so I was a private practitioner and then I incorporated 12 to Illinois Sports Medicine, I think, like, a year 13 later. I don't remember exactly, but right around 14 there.</p> <p>15 Q. Do you have a particular position or title here besides founder, I guess?</p> <p>16 A. I'm president of the corporation.</p> <p>17 Q. And could you briefly explain your job responsibilities as president and as a practitioner?</p> <p>18 A. Well, I'm just an orthopedic surgeon. Sub-S 19 corporation, so I just practice orthopedic surgery.</p> <p>20 Q. Have you ever held any teaching position in your role as a physician?</p>
<p>1 production. And then after that, it basically -- 2 there's different ways you can do it, but basically you 3 take an exam, so...</p> <p>4 Q. I am curious, with a JD, you pass the bar and then you are done with testing for the most part.</p> <p>5 A. Yeah. You guys are smarter than we are.</p> <p>6 Q. Are there any other professional certificates, licenses, or credentials that you have earned?</p> <p>7 A. I am board-certified in regenerative medicine.</p> <p>8 Q. And could you briefly explain what regenerative medicine is?</p> <p>9 A. Well, it deals with, in my case, platelet-rich 10 plasma, stem cell treatment. So it's an area that's 11 kind of grown up recently with trying to alter -- 12 beneficially alter your healing responses, your immune 13 system, that kind of thing.</p> <p>14 Q. No type of regenerative medicine was at issue in Mr. Burton's case?</p> <p>15 A. Correct.</p> <p>16 Q. Thank you.</p> <p>17 Let's walk again briefly through your work 18 experience. After you finished up, I believe, your 19 residency, was it, where did you go from there?</p> <p>20 A. So after my residency at Rush, I did a</p>	<p>Page 11</p> <p>1 A. Yeah. I was assistant professor for 25 years 2 at Rush, I was an instructor briefly at Northwestern 3 when I first started, as well as assistant professor 4 for 25 years at Rush. I retired from that two or 5 three years ago just -- actually, I still do research 6 down there, but just because you kind of have to be in 7 practice down there, and I migrated out to the suburbs. 8 And what else? I think I was an instructor or a fellow. 9 I don't remember exactly. And that's pretty much it.</p> <p>10 Q. We just did that drive, so I understand.</p> <p>11 What subjects were you instructing at Rush?</p> <p>12 A. So a couple of things. Basically as an 13 orthopedic surgeon, you work with residents. So 14 residents operate with you and you teach them how to do 15 to the cases that you do. I do research. So I do 16 computerized gait analysis research. They have a gait 17 laboratory down there. I'm still doing that down there. 18 So the academic side of it is like teaching residents 19 and then doing research. So that's mostly it.</p> <p>20 Q. I guess, any particular field of medicine?</p> <p>21 Was it orthopedic surgery that you were instructing?</p> <p>22 A. Yeah. So I would do, for example, an ACL 23 reconstruction and I have a resident and that's how they 24 learn. So they help with the case and you teach them</p>

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<p>1 things.</p> <p>2 Q. Would this include arthroscopic knee surgery?</p> <p>3 A. Yes. That's mostly what I do. When I started 4 out in practice, I did arthroscopic surgery and my 5 fellowship was heavily involved in that; but when I 6 first started in practice, we didn't -- ACL 7 reconstructions were not arthroscopic. Actually, I kind 8 of helped develop arthroscopic techniques for it. But 9 yeah.</p> <p>10 Q. Okay. So could we turn back to your CV? I 11 believe beginning on -- the Bates stamp is Burton BUR14. 12 You have a bibliography at the end?</p> <p>13 A. Uh-huh.</p> <p>14 Q. Is this a complete list of your publications?</p> <p>15 A. Yes.</p> <p>16 Q. Doctor, is it fair to say that your primary 17 focus in publication has been on ACL surgery?</p> <p>18 A. In publications, yeah.</p> <p>19 Q. Have you ever published any articles 20 addressing menisectomy in particular?</p> <p>21 A. Well, I published a paper on meniscal 22 allograft transplantation. So that's a procedure that's 23 done -- I think it's in here -- that if a person has a 24 total menisectomy and they have pain, then you can</p>	<p>Page 14</p> <p>1 "publish." So the second edition, I'm the editor of the 2 Comprehensive Textbook on the ACL for Orthopedic 3 Surgeons, the second edition of that, which is released 4 three months ago, four months ago. And so I edited -- I 5 wrote 15 -- There's 143 chapters; I wrote like 15 of 6 them then that people -- so we have a section in there 7 on pain, and so I edited -- So I solicited them and 8 edited those chapters but was not the author of them.</p> <p>9 Q. Understood. Congratulations on the recent 10 publication. I know a lot goes into that.</p> <p>11 A. Thank you.</p> <p>12 Q. Great. Thanks.</p> <p>13 So now I would like to turn to your prior work 14 as an expert in medical cases. You have served as an 15 expert in prior cases; is that right?</p> <p>16 A. Yes.</p> <p>17 Q. And your disclosures listed one case in the 18 past four years; is that correct?</p> <p>19 A. Can I ask you a question to answer your 20 question?</p> <p>21 Q. Please. Yes.</p> <p>22 A. So I -- Here and there people send me things 23 to review. So does being an expert mean looking at a 24 case for somebody, or does it mean being deposed or</p>
<p>1 transfer a cadaver graft in. So I published a paper on 2 that. And I -- Yeah.</p> <p>3 Q. Okay. Mr. Burton didn't undergo an allograft, 4 correct?</p> <p>5 A. No.</p> <p>6 Q. Okay. Great.</p> <p>7 Did you ever publish any papers on the 8 debridement of cartilage?</p> <p>9 A. No. No.</p> <p>10 Q. And, actually, am I pronouncing that 11 correctly? Is it debridement or debridelement?</p> <p>12 A. We usually say debridement, but debridelement is 13 okay.</p> <p>14 Q. I want to make sure I'm getting it right.</p> <p>15 Have you ever published any papers on 16 chondroplasty?</p> <p>17 A. No. I had a poster presentation at the 18 International Cartilage Repair Society on autologous 19 chondrocyte implantation, which is like cartilage 20 transplant. So chondroplasty is part of it, but it 21 wasn't the focus of it.</p> <p>22 Q. Okay. And have you ever published anything on 23 the treatment of postsurgical pain?</p> <p>24 A. Well, that kind of depends how you define</p>	<p>Page 15</p> <p>1 testifying? How would you define that?</p> <p>2 Q. Typically I would say you have been retained 3 and that you would prepare a report on behalf of the 4 client. You wouldn't necessarily have to testify. It 5 often does involve a deposition.</p> <p>6 A. So I don't do a lot of this, and I don't 7 really keep track of it. I can think of -- outside of 8 this one, there's one that I've been retained for right 9 now that I'm reviewing and there was one that I did a 10 couple of years ago where a guy asked me some questions 11 and I send him some reports and then he just stopped 12 asking me questions. But I think he paid me for the 13 report, you know. So those two, this one. That's all I 14 remember offhand. It's possible it's happened one other 15 time.</p> <p>16 Q. Are the people who reach out to you to ask you 17 to look at other documents lawyers typically?</p> <p>18 A. Yes.</p> <p>19 Q. Okay. We might follow up after the deposition 20 on that work.</p> <p>21 So you are working on this case?</p> <p>22 A. Yes.</p> <p>23 Q. You said you have been retained in another 24 case currently?</p>

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1 A. Correct. Yes.	1 we had just mentioned was Cuadrado.
2 Q. To the extent you can state -- I know certain	2 Do you recall Kenyon vs. The City of Evanston?
3 things are confidential -- is it a medical malpractice	3 A. No.
4 case?	4 Q. Do you recall, perhaps, Tsakalakis vs. The
5 A. No. It's a personal injury case.	5 Commissioner of Social Security? T-s-a-k-a-l-a-k-i-s.
6 Q. What part of the body is involved?	6 A. T-s what?
7 A. It's either the knee or the hip. I'm sorry.	7 Q. T-s-a-k-a-l-a-k-i-s.
8 Q. Okay. And you said there was one other case	8 A. Not really.
9 you worked on in the past several years; is that right?	9 Q. Todd vs. Martinez?
10 A. Yeah.	10 A. No.
11 Q. Was that the Cuadrados case?	11 Q. Levy vs. The Minnesota Life Insurance Company?
12 A. I don't think so. If you say so, maybe, but	12 A. No.
13 it doesn't range bell. Cuadrados?	13 Q. Mohamad vs. The Hilton Hotels Corporation?
14 MR. LOMBARDO: Cuadrado.	14 A. No.
15 MR. O'HARA: Cuadrado. Excuse me.	15 Q. Goodman vs. The Morton Grove Police Pension
16 BY THE WITNESS:	16 Board?
17 A. I hate to say this, it doesn't ring a bell.	17 A. No.
18 Maybe that was the name of the person.	18 And to be clear, the depositions that I do,
19 Q. It would have been a Cook County, Illinois	19 and I probably do one every other month, are as a
20 Workers' Compensation matter. Luis Cuadrado vs.	20 treater in personal injury cases, you know.
21 Paschen?	21 Q. And many of these might indeed be that.
22 A. Maybe. You know, I was asked -- So an IME	22 A. So I'm sorry to not remember, but I treat a
23 where you do an impairment rating, that doesn't count,	23 lot of patients and I don't necessarily remember who I
24 right?	24 do a deposition on.
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1 Q. Could you say that again? I'm sorry, Doctor.	1 Q. Don't apologize.
2 A. Somebody asked me to do an impairment rating.	2 So I apologize. A few more just in case you
3 I think it was workers' comp.	3 do recall being deposed or providing a report.
4 Q. What goes into an impairment rating?	4 Bruszniewski vs. The Atlantic American Fire
5 A. There is a book of rules, the different	5 Protection Co.?
6 categories of them. So Illinois has one; other states	6 A. No.
7 have one. And then if someone is impaired from an	7 Q. Poierier vs. Hernandez?
8 injury, say, then you look at what the diagnostic is	8 A. No.
9 when you look at other mitigating or exacerbating	9 Q. Smith vs. Community College District 508?
10 factors and you apply a number, a percent impairment for	10 A. No.
11 that body part and for their whole body. It's called an	11 Q. Kolovos vs. The Cook County Sheriff?
12 impairment rating.	12 A. No.
13 Q. And this goes to a workers' compensation panel	13 Q. Wals vs. Badowski?
14 presumably?	14 A. No.
15 A. Yes.	15 Q. Carroll vs. Kleiber?
16 Q. Are you paid for that work?	16 A. No.
17 A. Yes.	17 Q. Gilkey vs. The Brookside Condominium
18 Q. Okay. So I have a list of cases in which you	18 Association?
19 have been involved possibly as an expert or possibly	19 A. No.
20 doing an impairment rating or perhaps as a treating	20 Q. Los Iwona vs. Tlueka?
21 physician. I'm going to go through them. If you could	21 A. No.
22 provide details, that would be helpful. If you don't	22 Q. Sorkin v. Sun?
23 remember, you can tell me you don't remember because I	23 A. No.
24 have to admit, they go back some ways. I think the one	24 Q. Leger vs. The Tribune Co.?

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1	A. No.	1	So I can think of maybe a couple I've done. So there
2	Q. Hammerl vs. US Postal Service?	2	are doctors, I think, that do a lot of work for defense
3	A. No.	3	and they, like, market themselves. But, so...
4	Q. DV v. US Postal Service?	4	Q. So when you do impairment ratings, is that
5	A. DV?	5	typically for a plaintiff or on the defense side?
6	Q. The plaintiff's name is listed as DV. So they	6	A. Well, the last one I did was plaintiff because
7	must have been kept anonymous for some reason by the	7	it was a patient and I think the attorney asked me to do
8	Court.	8	it. So I think it would be plaintiff, right? Because
9	A. No.	9	these would pretty much derive out of patients I take
10	Q. Montalbano vs. The University of Illinois	10	care of. And I don't think an insurance company has
11	Hospital?	11	ever solicited me. Because that would be defense,
12	A. Montalbano, I at least remember the patient.	12	right?
13	And, actually, I still see her, but...	13	Q. Right.
14	Yeah, so I don't know. I might have gotten	14	A. So I don't think I've done any for defense.
15	deposed as a treater for her, I guess.	15	Q. Okay. Great.
16	Q. Okay. Marziarz v. Alicia Cleaning Service?	16	Other than in this case, have you ever served
17	A. No.	17	as an expert for the defendant Dr. Ghosh?
18	Q. Pettigrew v. US Postal Service?	18	A. No.
19	A. No.	19	Q. Have you ever served as an expert for Wexford?
20	Q. Basis v. Marriott?	20	A. No.
21	A. Basis?	21	Q. Have you ever served as an expert for the
22	Q. Yes.	22	plaintiff, Mr. Burton?
23	A. No.	23	A. No.
24	Q. Thank you for bearing with me.	24	Q. Prior to this case, have you ever worked for
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1	Generally speaking, let's say for cases that	1	Cassiday Schade?
2	you have been deposed as an expert, typically have you	2	A. Yes. The other one that I mentioned now is
3	been on the plaintiff's or defendant's side?	3	from them.
4	A. Well, the one currently is defense. And I	4	Q. The current one?
5	think the one where I was asked my opinion over a period	5	A. Yes.
6	of time and then it kind of went away, I think that was	6	Q. Any previous cases with Cassiday?
7	defense. And those are the -- So as an expert, you	7	A. I don't think so. They may have asked me
8	said, right? Because as a treater --	8	about somebody like a few months ago, but maybe one
9	Q. Yes.	9	more, maybe not. I don't think so though.
10	A. -- I think it's on behalf of my patient, you	10	Q. And could you tell me who the lawyer is or are
11	know.	11	that you are working on with that case?
12	And as I sit here, I had one a long time ago.	12	A. I may get this confused. So there's a
13	I remember that was, I think, plaintiff, actually. So	13	Mr. Panatera in this case.
14	as I sit here, I think I can remember three. I think	14	Q. Yes. Correct.
15	two were defense and one was plaintiff.	15	A. So there's an attorney whose name I think is
16	Q. Okay. And then you do testimony as a treating	16	Stiepfold (Phonetic). I don't know. Maybe he is not
17	physician?	17	with Cassiday. I don't know.
18	A. Yes.	18	Q. Sure. He might be.
19	Q. And you also sometimes provide -- I forget the	19	A. I kind of remember the name Stiepfold.
20	term.	20	Q. Gorsky?
21	A. Impairment ratings.	21	A. Gorsky?
22	Q. Impairment ratings. That's right.	22	Q. Yeah, Steve Gorsky.
23	A. I was trained to do it, and I just don't get	23	A. No. It's like S-t-i-e-p-f-o-l-d, something
24	asked to do it very often. I was recently, I remember.	24	like that. That's the only lawyer's name that pops into

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1 my head. So I think that's out there. I think that's 2 another one.	1 Q. Yes. 2 A. To tell you the truth, I don't know that 3 either. I might have. They might have given me 4 something to sign. I don't know.
3 Q. So how often would you say you served as an 4 expert where you are actually retained and produce a 5 report, by a lawyer?	5 Q. At what point -- But there's an agreement in 6 place between you and the firm to provide services in 7 this case, correct?
6 A. So they pay me something to do something like 7 a report?	8 A. Well, what I can tell you for sure is that 9 somebody communicated with me and said there was this 10 case and, I think, told me a little bit about it and I said 11 asked if I was interested in reviewing it and I said 12 yes. And they asked me what I charge and I told them 13 what I charge. And I think I sent them a bill, you 14 know. So that much has happened. Beyond that, as far 15 as the formal paperwork accoutrements, I really don't 16 remember.
14 Q. So ballpark, in the last ten years, would you 15 say greater or less than five?	17 Q. Okay. So to your knowledge, you haven't 18 executed a formal retainer agreement?
16 A. Maybe right around five.	19 A. I may have. I honestly don't really pay a lot 20 of attention. I sign a lot of stuff, you know. I may 21 have.
17 Q. Okay.	22 Q. Okay.
18 A. Less then ten, I think, you know.	23 A. They seem like honorable people, so I probably 24 have like a few legal agreements, you know.
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1 case will be the most it's ever been. 2 Q. All right. Thank you. 3 A. Sure. 4 Q. I would like to talk about your work, I guess, 5 in this matter in particular. How did you first learn 6 about this case? 7 A. I was called by the attorney. 8 Q. Was it Joe Panatera who first reached out to 9 you? 10 A. I have talked to him more lately. It might 11 have been him. 12 Q. It was a lawyer from Cassidy? 13 A. It was from Cassidy. 14 Q. And when were you first contacted? 15 A. Oh, gosh. I don't know that I exactly 16 remember. Maybe six months. 17 Q. Six months ago? 18 A. Yeah. I don't really remember, but it wasn't 19 two years and it wasn't last week, so... 20 Q. Have you been formally retained to work as an 21 expert on this matter? 22 A. So forgive me. I'm not sure that I know what 23 "formally retained" means. Did I sign some kind of a 24 contract with them?	1 Q. And what was your assignment in this matter? 2 A. My assignment? 3 Q. What were you asked to do? 4 A. I was asked to review the case and give 5 opinions of relevant parts of it, I think. 6 Q. Gotcha. 7 And you have received compensation in 8 connection with your work in this case so far? 9 A. Yes. 10 Q. And do you know how much you been paid to 11 date? 12 A. Yeah. I got a check today for \$4,000. It's 13 \$1,000 an hour for what might be a four-hour deposition. 14 MR. O'HARA: Howard, can you hand me the next 15 binder? 16 MR. KAPLAN: Number 3? 17 MR. O'HARA: Yes. I'm holding a document entitled 18 response to Deposition Rider to Dr. Prodromos and I'm 19 going to mark it as Plaintiff's Exhibit 2. 20 (WHEREUPON, a certain document was 21 marked Plaintiff's Deposition 22 Exhibit No. 2, for identification, 23 as of 01/04/2018.)

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1 BY MR. O'HARA:	1 Q. Did you have any support staff working with
2 Q. Do you recognize this document, Doctor?	2 you for your expert work on this matter?
3 MR. O'HARA: And for the record, this has been	3 A. Not really. The only support I had was the
4 given the Bates stamps of Burton 19 through 33.	4 same woman. She like gives me things, you know. I
5 BY THE WITNESS:	5 mean, she will give me records or discs or paper. But,
6 A. Do I recognize it? I mean, it's a document	6 no, I did not have anybody review what was in the
7 relating to this case. Do I remember the pieces of	7 records.
8 paper and what's on it? Not really.	8 Q. So she performed clerical tasks, you could
9 Q. Okay. So to clarify, I guess there's a couple	9 say?
10 parts of this document. The first is Response to	10 A. Yes.
11 Plaintiff's Exhibit Rider of Dr. Prodromos, which was	11 Q. Okay. But you were the only person doing
12 signed by Joseph Panatera, opposing counsel in this	12 substantive review --
13 case. And then there's a series of what looks like fax	13 A. Correct.
14 messages and e-mails between Joe Panatera and yourself.	14 Q. -- of the records?
15 Is that correct?	15 A. Correct.
16 A. I guess.	16 Q. Okay. How did you receive the documents that
17 Q. And in this case you charged \$2,000 for a	17 you reviewed in this case?
18 chart review and phone time; is that correct?	18 A. Some of them I got, maybe all of them, via
19 A. Yes.	19 e-mail for files. When I was reviewing it, you know --
20 Q. And what did that entail, that work?	20 so basically that. There might have been -- I don't
21 A. You know, reviewing. So I was given records,	21 think any paper was sent. I think that's all there was.
22 so I reviewed the records for the case and then we spoke	22 Q. So if you look at Exhibit 2, there's a series
23 on the phone.	23 of e-mails from Mr. Panatera to yourself. I believe he
24 Q. And you are charging \$4,000 for your time	24 sent five attaching a series of documents. Does that
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1 today?	1 conform with your recollection?
2 A. Yes. It's \$1,000 an hour for live time and we	2 A. I really don't recall. I was looking at it
3 had to book the four, so yeah.	3 and I have a digital file and a digital file has a
4 Q. Sure. So you charge on an hourly basis for	4 variety of, you know, records from various places or
5 your services as an expert?	5 various people. I don't know if it was five. I think
6 A. Yes.	6 the total number of files was probably more than five.
7 Q. And how much do you charge per hour?	7 In fact, I'm sure it was more than five.
8 A. So for face time, as it were, \$1,000; and for	8 Q. I think there might have been multiple files
9 paperwork, \$500 an hour.	9 and several e-mails.
10 Q. Sure. And are you reimbursed for expenses or	10 A. Yeah. There are redundant e-mails too, and I
11 costs?	11 asked her to aggregate all the stuff again so I could
12 A. I don't know. If there were some, maybe I	12 make sure I wasn't missing anything. So I think these
13 would ask. I don't think there are any expenses. I	13 things were sent redundantly on my behalf because I
14 don't think so. No, no expenses or costs.	14 wanted to make sure I didn't lose anything.
15 Q. Is your compensation in this matter in any way	15 Q. And you believe the universe of documents you
16 dependent on the outcome of this case?	16 received were sent through those e-mails?
17 A. No.	17 A. You said the universe of documents? The
18 Q. And do you send your bills directly to the	18 totality of them?
19 Cassidy firm?	19 Q. The totality of them.
20 A. As opposed to what?	20 A. Well, for sure they were sent through e-mail.
21 Q. Any other method, I suppose.	21 Whether there was like a disc sent as well, that's
22 A. So I have a woman in the office and we do	22 possible.
23 these things. I tell her what I did, and then she talks	23 Q. Okay. Have you received e-mails -- Excuse me.
24 to them and gets paid. So from the firm, yes.	24 Have you received any documents for your

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<p>1 review from anyone outside the Cassidy firm?</p> <p>2 A. No.</p> <p>3 Q. Could we go back to Exhibit 1, your expert</p> <p>4 report? If you would turn to Bates stamp BUR5, we have</p> <p>5 a listing of materials reviewed.</p> <p>6 A. Okay.</p> <p>7 Q. These are plaintiff's complaint at law; the</p> <p>8 defendant, Dr. Ghosh's answer to the complaint;</p> <p>9 Wexford's answer to the complaint; the plaintiff's</p> <p>10 deposition transcript; Dr. Ghosh's transcript;</p> <p>11 plaintiff's medical records from the University of</p> <p>12 Illinois at Chicago; plaintiff's medical records from</p> <p>13 the Illinois Department of Corrections; plaintiff's</p> <p>14 grievances from IDOC; the expert report of Vincent</p> <p>15 Cannestra, M.D.; and Dr. Cannestra's deposition</p> <p>16 testimony.</p> <p>17 A. Okay.</p> <p>18 Q. Is it true that you reviewed those materials?</p> <p>19 A. Yes.</p> <p>20 Q. And did you review any materials outside of</p> <p>21 those listed in this list?</p> <p>22 A. Well, I reviewed -- There were Stateville</p> <p>23 records and there were U of I records and there were</p> <p>24 Pontiac records. So I don't know -- None of these say</p>	<p>Page 34</p> <p>1 you that you got on your own?</p> <p>2 THE WITNESS: No. That being the case, then I</p> <p>3 guess it's probably everything.</p> <p>4 MR. O'HARA: Thank you.</p> <p>5 MR. LOMBARDO: Sorry to interject.</p> <p>6 MR. O'HARA: No, not at all. I appreciate it.</p> <p>7 It's helpful.</p> <p>8 BY MR. O'HARA:</p> <p>9 Q. Are there any documents that you reviewed in</p> <p>10 your work in this case, that you reviewed but decided</p> <p>11 not to rely on?</p> <p>12 A. There were some that were less relevant than</p> <p>13 others, but what you just said would seem to me to be</p> <p>14 that I reviewed it and thought that it was specious,</p> <p>15 something, I don't know. So nothing like that.</p> <p>16 Q. That's fair.</p> <p>17 Did you bring any documents with you to the</p> <p>18 deposition?</p> <p>19 A. Yes. I brought some notes that I took.</p> <p>20 Q. Do you have those with you?</p> <p>21 A. Yes. It's a one-page thing.</p> <p>22 MR. LOMBARDO: We can make a copy of that for you</p> <p>23 guys if you want.</p> <p>24 MR. O'HARA: If we could do that during a break,</p>
<p>1 Pontiac. It's Pontiac, but it's not labeled Pontiac; is</p> <p>2 that right?</p> <p>3 Q. Pontiac and Stateville records both would have</p> <p>4 come under the Illinois Department of Corrections.</p> <p>5 A. Okay. Did I review anything else? Not that I</p> <p>6 recall offhand.</p> <p>7 Q. To your knowledge, is this a complete list of</p> <p>8 materials that you reviewed in this matter?</p> <p>9 A. Yes. Don't completely hold me to it, but I</p> <p>10 think so.</p> <p>11 Q. I think we do have to hold you to, at some</p> <p>12 point, what materials you reviewed as far as you know.</p> <p>13 A. Well, you know, they're on my computer, on my</p> <p>14 little discs. I don't have this handy, so this looks</p> <p>15 pretty much like it. But absent that list, I could not</p> <p>16 guarantee it. So I don't want to give you just an</p> <p>17 offhand answer.</p> <p>18 Q. Maybe we could take a break at some point</p> <p>19 later and you could briefly -- Do you have the computer</p> <p>20 with you?</p> <p>21 A. No. I would have to go home and get it. It's</p> <p>22 at home.</p> <p>23 MR. LOMBARDO: This is everything we provided,</p> <p>24 Dr. Prodromos. Is there anything that we didn't provide</p>	<p>Page 35</p> <p>1 that would be great.</p> <p>2 MR. LOMBARDO: It looks like an abstract of some</p> <p>3 relevant dates.</p> <p>4 MR. O'HARA: Thank you. That's very helpful.</p> <p>5 BY MR. O'HARA:</p> <p>6 Q. Were there any documents you would have liked</p> <p>7 to have reviewed that Counsel did not provide you?</p> <p>8 A. No.</p> <p>9 Q. Let's turn back to Exhibit 2 if you don't</p> <p>10 mind. On the second page there was a request D. We had</p> <p>11 requested copies of citations of any and all textbooks,</p> <p>12 reference works, periodicals, and any other published</p> <p>13 documents upon which the witness relies in support of</p> <p>14 your opinions. In response, your counsel directed us to</p> <p>15 your CV and, quote, all documents and presentations</p> <p>16 referenced in the CV. Is that correct?</p> <p>17 A. Yeah, I guess so.</p> <p>18 Q. As we discussed earlier, in Exhibit 1 on your</p> <p>19 CV, the bibliography lists a number of publications.</p> <p>20 Did you rely on each article and presentation listed or</p> <p>21 on some in particular or all of them simply generally?</p> <p>22 A. So the best way I can answer that is that I</p> <p>23 pretty much rely on the sum and substance of, you know,</p> <p>24 all the literature with which I'm conversant. So to</p>

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1 answer you specifically, no, there's no one document 2 that I relied on if that's the crux of your question. 3 Q. That is. Thank you. 4 As far as today's deposition is concerned, did 5 you do anything in preparation? 6 A. I did, yeah. I just reviewed things again. 7 Q. Sure. Could you describe any preparation you 8 undertook? 9 A. Can I describe what I did? 10 Q. Yes. 11 A. I had taken notes and reviewed everything for 12 the first time we were supposed to do this when -- I 13 apologize -- I got sick. And so I just got my notes out 14 again and looked at that, looked at the Stateville one 15 in particular one more time. 16 Q. Did you meet with Counsel in preparing for 17 this deposition? 18 A. Well, I met with Counsel prior to the 19 deposition on-site today for a little bit. 20 Q. Okay. Did you have any phone calls prior to 21 the deposition today? 22 A. Myself, no. The office did to schedule it. 23 But no. 24 Q. So you met with Counsel in person for the	1 notes. 2 Q. You reviewed those notes? 3 A. Yes. I just told him I was going to have 4 this. I just said I have these notes that I am bringing 5 with me. 6 Q. But you didn't review any case documents? 7 A. No. 8 Q. Okay. Have you had communications with any 9 other experts in this case? 10 A. No. 11 Q. Okay. Terrific. 12 And one more follow-up before we get into the 13 substance of the report. In your work as an expert, so 14 not necessarily as a physician but as an expert, have 15 you ever taken part in any cases where any party was 16 incarcerated? 17 A. Besides this one, right? 18 Q. Besides this one. 19 A. I don't think so. 20 Q. And do any of the patients you treat as a 21 physician, currently or in the past, have they been in 22 prison or jail? 23 A. I mean, I have had a couple, a few over the 24 years. I don't think -- I definitely don't have anybody
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1 first time today prior to the deposition? 2 A. Yeah. I think the last call I had was 3 Mr. Panatera, I think. Yeah. So yeah. Yes. 4 Q. And when was your last call with Mr. Panatera? 5 A. You know it was a while ago. I don't remember 6 exactly. A couple of months, maybe. 7 Q. Okay. How long did your phone conversations 8 with Counsel from Cassiday last in total? 9 A. So unlike you guys, I don't even really keep 10 track. I think the last one might have been a half-hour 11 or something. 12 Q. How long did your meeting today last? 13 A. Like 25 minutes. 14 Q. Was anyone else present during your meeting 15 today? 16 A. No. 17 Q. And was anyone else present on your previous 18 phone calls -- 19 A. No. 20 Q. -- with the attorneys? 21 A. No. 22 Q. Did you review any documents with Counsel 23 during these meetings? 24 A. No. Well, these notes, I showed him these	1 now. I mean, like were they in jail when I was taking 2 care of them? 3 Q. Or they might be brought here on an outpatient 4 visit from jail? 5 A. So like jail prisoners that I took care of. 6 There may have been one or two a long time ago but not 7 many and not for a while. 8 Q. Not recently? 9 A. No. 10 Q. Okay. Thank you. 11 So let's turn to your report itself. I think, 12 beginning on page BUR7. So on page BUR7 you list your 13 opinions in this case. And you say, The following 14 opinions are given with a reasonable degree of medical 15 certainty and are based upon my knowledge, experience, 16 training, and education. Could you please read your 17 opinions in this case? 18 A. Dr. Ghosh and the medical staff at Stateville 19 complied with the standard of care regarding the 20 treatment provided to Mr. Burton at that facility 21 subsequent to the procedure performed at UIC on 22 October 19, 2010. 23 Q. Could you read each of them, Doctor? 24 A. Number 2, the arthroscopic knee surgery that

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<p style="text-align: right;">Page 42</p> <p>1 Mr. Burton underwent on October 19, 2010, is a minimally 2 invasive procedure and cannot be attributed to causing 3 Mr. Burton's significant pain.</p> <p>4 Number 3, Tylenol 3 with codeine is an appropriate substitute for Norco in treating Mr. Burton for any acute pain he may have been experiencing immediately following the October 19, 2010 arthroscopic knee surgery.</p> <p>5 Number 4, Dr. Ghosh complied with the standard of care when he substituted ibuprofen for Tylenol 3 with codeine after the acute state of Mr. Burton's postoperative treatment.</p> <p>6 THE REPORTER: I'm going to have to ask you to slow down.</p> <p>7 THE WITNESS: I'm sorry.</p> <p>8 BY THE WITNESS:</p> <p>9 A. So number 4, Dr. Ghosh complied with the standard of care when he substituted ibuprofen for Tylenol 3 with codeine after the acute stage of Mr. Burton's postoperative treatment because it is an effective and much less dangerous medication for treating any pain Mr. Burton may have been experiencing.</p> <p>10 Number 5, Dr. Ghosh complied with the standard of care by providing Mr. Burton with an immobilizing</p>	<p style="text-align: right;">Page 44</p> <p>1 Q. In your report. 2 A. Did I include anything else in the report? I don't think so.</p> <p>3 Q. So that represents the complete list of your opinions that you developed for your report? 4 A. I think, yes.</p> <p>5 Q. Okay. And I think that's the last time we are going to be reading long stretches.</p> <p>6 And you claim that the bases for your opinions are, quote, my education and experience as well as my review of the above-referenced records, end quote; is that correct?</p> <p>7 MR. LOMBARDO: Object to form. I think that mischaracterizes what he said.</p> <p>8 But go ahead.</p> <p>9 BY THE WITNESS:</p> <p>10 A. Well, there was -- I also said training. So it says, Are based on my education, training, experience, and knowledge. I think what I just read is more accurate. I think what you read is something a little different.</p> <p>11 Q. Sure. I can read that. So the bases of your opinions are your education, experience, training, and knowledge; is that correct?</p>
<p style="text-align: right;">Page 43</p> <p>1 knee brace, crutches, a low bunk permit, and physical therapy. In addition, I see -- I'm sorry -- to anti-inflammatory medication, subsequent to his October 19, 2010 arthroscopic knee surgery.</p> <p>2 Number 6, any complaints of problems after the first week after surgery are unrelated to Mr. Burton's postoperative acute pain and it would not be clinically appropriate to treat any such medicines with dangerous opioid medication.</p> <p>3 Q. Just in the end there, I believe it would not be clinically appropriate to treat any such symptoms with dangerous opioid medication.</p> <p>4 A. Yes. I'm sorry.</p> <p>5 Q. Not at all.</p> <p>6 Are these opinions you developed in this case?</p> <p>7 A. Yes.</p> <p>8 Q. And is this the complete list of your opinions in this matter?</p> <p>9 A. Were there other opinions? Is that what you're asking?</p> <p>10 Q. Correct.</p> <p>11 A. Well, I mean, I might have other opinions on other things if I were asked other things.</p>	<p style="text-align: right;">Page 45</p> <p>1 A. Yes.</p> <p>2 Q. And are these the bases for each of the six opinions? 3 A. Yes.</p> <p>4 Q. Okay. So let's turn to opinion number 1. Dr. Ghosh and the medical staff at Stateville complied with the medical standard of care. What documents did you consider in reaching that opinion? 5 A. Firstly, the Stateville records from when he came back -- I guess it was called the infirmary, I'm not sure, but there were nurse's notes and such for the day of and the first few days after his return. 6 Secondly, the report of surgery by the operating surgeon, and I looked at a number of the documents, but pretty much those. 7 Q. You would say the Stateville records and the surgery report are the two primary bases for that opinion? 8 A. Yes.</p> <p>9 Q. What particular facts did you rely in reaching that opinion? 10 A. Well, I can quote or paraphrase from the medical record. The things that were particularly persuasive to me. So firstly there's the procedure</p>

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<p>1 itself. He had an arthroscopic knee surgery. 2 Arthroscopy is inherently a minimally invasive 3 procedure, just two little punctures in the skin as you 4 know. However -- and I'm an arthroscopic surgeon; 5 almost all my surgery now is arthroscopic -- within the 6 broad rubric of arthroscopic surgery, there are more and 7 less invasive ones.</p> <p>8 So in his case, for example, he had a lateral 9 menisectomy, a partial menisectomy. So menisectomies -- 10 and I just did one a couple hours ago -- can involve 11 biting pieces of the meniscus and they can involve 12 cranking on the knee and opening it up. And it's not a 13 big deal no matter what, but some are more invasive than 14 others.</p> <p>15 In his case all he had was shaving of the 16 central border. So that's -- it's kind of a stretch to 17 call it a menisectomy. I mean, it is, but it's -- you 18 do very little. You just stick a little shaver in 19 there. The meniscus itself has no nerve endings. You 20 don't have to torque the knee to open it up. So as 21 menisectomies go, it was extremely minor. He had a 22 loose body removed, which is just kind of a thing 23 floating around in the knee. You are not cutting 24 anything; you are not cranking on the knee; you just</p>	<p>Page 46</p> <p>1 mode of pain relief for patients. We use ice primarily. 2 We use medications of any kind secondarily. Though he 3 was iced, so I thought that was good. And he was given 4 Tylenol with codeine.</p> <p>5 So you are asking me what I relied on or what 6 was persuasive for this first opinion. Got it. Okay. 7 So the ice certainly complies with the standard of care. 8 Tylenol 3. So I gather this is the point of contention 9 in this case and I don't want to digress too much, but 10 the issue came up -- perhaps I can say that 11 Dr. Cannestra stated at some point, I think, that he 12 didn't think that was an appropriate thing for 13 post-arthroscopy and one thing and another. But, 14 actually, it used to be used fairly often. It isn't 15 used as much anymore, but for no particular reason. 16 Tylenol 3 has 30 milligrams of codeine per tablet. 17 Codeine -- an equianalgesic dose of hydrocodone, which 18 is probably more frequently used, is 6 to 1. So a 19 classic Vicodin is a 5-milligram hydrocodone tablet, 20 which is often used for this. That is the same 21 analgesic, equianalgesic opioid effect as a single 22 Tylenol 3. And two Tylenol 3, which is what he ordered, 23 is the same as 10 of hydrocodone, which is kind of a lot 24 for a simple scope.</p>
<p>1 stick a little grabber in there to remove it.</p> <p>2 He had a chondroplasty of his medial femoral 3 condyle. So that is the same thing; it's kind of 4 shaving little fronds, if you will, of what's called 5 articular cartilage. So, again, that articular 6 cartilage has no nerve endings. There are other more 7 invasive things like the thing I just did, the 8 microfracture. I poked little holes in the bones. Bone 9 does have nerve endings; cartilage doesn't.</p> <p>10 So, basically, in looking at arthroscopy, his 11 was -- there was very, very little done and nothing 12 really that would cause any pain except for the fact 13 that there is certainly pain involved just from sticking 14 the scope in your knee. It's like getting stabbed with 15 a little spear.</p> <p>16 So the first thing was to see exactly what did 17 the doctor do when he was in there. And it was not 18 much, number one.</p> <p>19 Number two, at the Stateville -- first of all, 20 the patient stated his pain -- this was the day of 21 surgery. The first note that I saw from the nurse was 5 22 on a scale of 1 to 10, which, for a postoperative 23 patient, is not particularly severe. He was then given 24 at 3:55 -- he was iced, which is actually my primary</p>	<p>Page 47</p> <p>1 My point being -- you know, the question was: 2 Because he switched to Tylenol 3 from the hydrocodone, 3 was he being undermedicated. And, in fact, he wasn't. 4 In fact, it's an equianalgesic dose, maybe more than he 5 would have needed. So that was relevant to me.</p> <p>6 And then at 5:00 p.m. it mentioned that 7 again -- it didn't specify, but that note in particular 8 said two Tylenol 3 tablets were given. So that's strong 9 stuff. And when I first started in practice, people 10 used Tylenol 3 and Tylenol 4 a lot. Why don't they now? 11 No particular reason. I think it's just fashion. So 12 what matters is equianalgesic dose and it's fine and has 13 less, actually, abuse potential for hydrocodone, anyway.</p> <p>14 So then at 3:00 a.m., the nurse notes -- First 15 of all, she notes that her pain meds were given. So the 16 question is these were ordered; were they, in fact, 17 given. But from the nurse's notes, it appears they were 18 and that the patient, quote, slept good, closed quote, 19 indicating he was comfortable.</p> <p>20 So the standard of care being was he 21 adequately treated by Dr. Ghosh who -- in whose care he 22 was at that time, and these things all indicate that he 23 was. At 11:30 a.m. it is noted, quote, The knee is 24 slightly swollen, closed quote, the idea being slightly.</p>

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<p>1 So the point being slightly, not severely swollen. And 2 then about the wound, quote, it says, No discharge or 3 bleeding, covered the wounds with Betadine, closed 4 quote.</p> <p>5 So, you know, the wounds looked good. The 6 nurse was attentive. I know there's an issue 7 elsewhere -- it may not relate to this at all -- about 8 whether the patient was neglected; his dressing was 9 never changed; the stiches weren't taken out. But here 10 the dressing was clearly changed because the nurse 11 examined it and covered it with Betadine, and you can't 12 do that unless you change the dressing. So he was -- 13 and this is the next morning. And that's typically what 14 one will do, is change it the next day, although you can 15 leave dressings on much longer.</p> <p>16 And then there's a note, I think, from that 17 same time that says as far as the Motrin that was given. 18 It says, quote, Motrin 400, one to two tablets Q eight 19 hours PRN times 30 days, closed quote. So ibuprofen is 20 a pretty good analgesic. And, again, we talk about 21 equianalgesic doses of medicine. So 2200 -- so two 400s 22 Q eight, every eight hours, would be -- so two tablets 23 three times a day, that's 2400 milligrams a day. The 24 equianalgesic dose for 10 milligrams of hydrocodone,</p>	<p>Page 50</p> <p>1 are monitoring the situation. So I think it's kind of a 2 lot for this, but it's not wrong for that surgeon to 3 have done that. But it's incumbent -- but that surgeon 4 is out of the picture now. Dr. Ghosh is taking care of 5 him. And it's the mark of a good doctor, which he is, 6 that he evaluated the patient, that he gave him 7 appropriate medicines for what his problem was.</p> <p>8 So I think he exceeded the standard of care 9 because I don't think a lot of doctors would have done 10 that. And I see people that are overmedicated all the 11 time. So and then, also, to get him on the ibuprofen 12 and off the narcotics also.</p> <p>13 And it also should be pointed out that, as 14 you, I'm sure, are aware, Mr. Burton was listed as being 15 bipolar and he had psychoactive drugs. I don't know how 16 many of those he was taking at the time. I know there 17 were issues with compliance with taking them; but 18 narcotics, unlike nonsteroidal anti-inflammatories like 19 Motrin, are psychoactive. So it's particularly 20 beneficial -- and I try to do this myself -- to not have 21 people taking multiple psychoactive drugs. So I thought 22 getting him off of even the Tylenol 3 because it was a 23 pretty significant dose of narcotic -- to getting him on 24 a perfectly adequate dose of a nonsteroidal, I thought</p>
<p>1 which would be two typical Vicodins is 2220. So the 2 point being that the stuff you buy over the counter for 3 Motrin is 200 milligrams, so it's much weaker. This is 4 prescription strength. So he was prescribed the 5 equivalent of 10 milligrams of -- so he was prescribed 6 an ibuprofen dose that was equianalgesic of 7 10 milligrams of hydrocodone, which should be more than 8 enough for what he had for this next day.</p> <p>9 Also persuasive to me, on the same day there 10 was a quote from the nurse, quote, No complaints of pain 11 or discomfort at this time, closed quote. So those -- 12 and I would add that I know that -- you know, I 13 understand there's a discrepancy; different people felt 14 different things about the care that he got, the 15 plaintiff and the defendant and such. But Dr. Ghosh is 16 to be absolutely commended because it is the easiest 17 thing in the world to give people lots of narcotics, and 18 very bad things happen. And so this doctor actually -- 19 he could have just as easily -- at least I think he 20 could have -- just have taken -- the doctor at the 21 hospital prescribed -- I don't have this written down 22 here -- but I think 50 milligrams -- 50 tablets of 23 hydrocodone.</p> <p>24 So, you know, you can prescribe more if you</p>	<p>Page 51</p> <p>1 was also a very good thing. 2 So those are the main points. 3 Q. Thanks, Doctor. 4 Let's turn back to BUR5 in your report which 5 begins Discussion. In that first paragraph you say, I'm 6 of the opinion that Dr. Ghosh and the medical staff at 7 Stateville Correctional Center complied -- 8 A. I'm sorry. Under Discussion? 9 Q. Right. In that first paragraph you say, I am 10 of the opinion -- I skipped the first part of that 11 sentence, I apologize, based on my education -- 12 A. I got it. 13 Q. I'm of the opinion that Dr. Ghosh and the 14 medical staff at Stateville Correctional Center complied 15 with the standard of care regarding the treatment 16 provided to Plaintiff, Alnoraindus Burton, at that 17 facility subsequent to the procedure performed at UIC. 18 That's one of your opinions, correct? 19 A. Yes. 20 Q. Do you believe the standard of care is 21 different for prisoners than from other patients? 22 A. No. 23 Q. And your opinion above says that Dr. Ghosh and 24 the medical staff at Stateville complied with the</p>

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<p>1 standard of care.</p> <p>2 A. Yes.</p> <p>3 Q. You don't identify which other medical staff 4 in particular; is that correct?</p> <p>5 A. I don't identify, no.</p> <p>6 Q. So is it your opinion that all Wexford staff 7 that treated Mr. Burton at Stateville following his 8 surgery complied with the standard of care?</p> <p>9 MR. LOMBARDO: Object to form.</p> <p>10 BY THE WITNESS:</p> <p>11 A. Well, I mean, I wouldn't want to be 12 responsible for every action that every healthcare 13 professional provided, but regarding the relevant -- 14 particularly the relevant -- and by the way, I reviewed 15 these records way the heck out for a long period of 16 time. But, yeah, I mean, I thought his care was good 17 overall.</p> <p>18 Q. So, I guess, maybe the way I could rephrase 19 that is: Who is encompassed within what you described 20 as the medical staff at Stateville?</p> <p>21 A. Pretty much the nurses is what I was thinking 22 of, the nurses at the time that I was just quoting from 23 that were delivering the meds.</p> <p>24 Q. So then if we move on, I believe the next</p>	<p>Page 54</p> <p>1 undergoing minor pain?</p> <p>2 A. Well, I don't know. Again, it's a question of 3 definition. What I write in my notes actually is I will 4 write appropriate postoperative pain. So I would say 5 that he had -- you know, see, it all depends. Is it 6 minor pain in the context of surgical procedures? It is 7 because it's a minor procedure. You know, is it -- so I 8 think it was appropriate pain, I think, in the total 9 spectrum of things. You know, comparing this to major 10 procedures, it was minor pain. I guess -- I don't know. 11 Probably the right thing to say would have been 12 "appropriate pain." It was appropriate to control the 13 pain that he had after this minor procedure.</p> <p>14 Q. Okay. But as far as the opinions you listed 15 in your report, your opinion didn't state that the care 16 was appropriate for moderate or severe pain; is that 17 correct?</p> <p>18 A. Well, if you are asking the words that I 19 wrote, I did not use the words moderate or severe, but I 20 didn't use them because he wasn't in them. So, yeah, 21 obviously that's correct. I didn't use those words, so 22 you don't need me to reaffirm that. But had he had that 23 kind of pain -- actually, had he had that kind of pain 24 prior to this, which there's no evidence that he did,</p>
<p>1 sentence, you say specifically, The medication that 2 Dr. Ghosh and the Stateville medical staff provided to 3 Plaintiff after his surgery was a safe and effective way 4 to control any minor postoperative pain that resulted 5 from this minimally invasive arthroscopic procedure. 6 That's another one of your opinions, correct?</p> <p>7 A. Right.</p> <p>8 Q. In this opinion you don't opine that it was an 9 effective way to control moderate or severe 10 postoperative pain, do you?</p> <p>11 A. Those are not the words that I used, although 12 he wasn't in severe pain by his own admission.</p> <p>13 Q. So let me just ask that again. It's not your 14 opinion that the treatment Dr. Ghosh and the Stateville 15 medical staff provided was safe and effective to control 16 moderate or severe pain?</p> <p>17 A. To tell you the truth, what I probably should 18 have said here -- It all depends upon how you want to 19 phrase it. Certainly moderate, severe -- you see, it 20 depends how you want to define -- The best way to say 21 this is that it was appropriate to control the pain that 22 the patient had. Probably I should have left the 23 modifier off entirely.</p> <p>24 Q. But it's your opinion that Mr. Burton was</p>	<p>Page 55</p> <p>1 then it would have been effective for that because it 2 controlled his pain pretty well. Do you know what I 3 mean?</p> <p>4 Q. Right. But you did use the word "minor" in 5 the opinion, so I'm just trying to clarify. Your 6 opinion is limited to the fact that it was a safe and 7 effective way to control minor postoperative pain, not 8 moderate or severe postoperative pain?</p> <p>9 MR. LOMBARDO: Objection. Form.</p> <p>10 BY THE WITNESS:</p> <p>11 A. I don't think what you are saying is true. 12 And if you are indeed asking me to clarify -- that's 13 what you just said -- I attempted to clarify the meaning 14 of the word in that context. So had he not had any pain 15 medicine, maybe he would have had moderate or severe 16 pain, but he didn't. So if you are looking for a 17 clarification, that's the clarification.</p> <p>18 So I think it kind of sounds like you are 19 saying if he had moderate or severe pain, this would 20 have been grossly inadequate. And you really can't say 21 that because he didn't have it. In fact, all you can 22 really do, which Dr. Ghosh did, is what a good doctor 23 would do, which he recorded too is you titrate the 24 patient's pain to the medication they are getting. You</p>

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<p style="text-align: right;">Page 58</p> <p>1 don't want them to have severe pain because then you 2 would have been undermedicating them, and that never 3 happened.</p> <p>4 And it might have been if he had -- if he had 5 severe pain before, which there's no evidence that he 6 did, it might have been okay for that. That's the 7 equivalent of ten hydrocodone. That's a lot. The two 8 T3s is more than I would have given him initially. He 9 could have had severe pain and that could have been 10 enough to control it, but there's no way to know. What 11 he manifested with was minor; that's why I said minor.</p> <p>12 Does that clarify.</p> <p>13 Q. Yeah. But in your report you don't offer 14 opinions as to what would have been appropriate for 15 moderate or severe pain; is that correct?</p> <p>16 MR. LOMBARDO: Objection. Form.</p> <p>17 BY THE WITNESS:</p> <p>18 A. Yeah. I mean, right. I could have elaborated 19 more in those what would have been hypotheticals to my 20 way of thinking and did not.</p> <p>21 Q. Okay. You touched on this a little bit 22 earlier, but could you explain what makes an 23 arthroscopic procedure minimally invasive?</p> <p>24 A. Sure. First of all, it is invasive because</p>	<p style="text-align: right;">Page 60</p> <p>1 Q. What would you describe as a significantly 2 invasive arthroscopic procedure within that range? 3 A. You mean what would I call one that would be 4 likely to produce more pain?</p> <p>5 Q. Well, you described it as a minimally invasive 6 arthroscopic procedure, and so I'm -- and you said 7 there's a range within it for what is more or less 8 invasive. So I guess I'm wondering --</p> <p>9 A. It's not really that -- I'm sorry. I 10 interrupted you.</p> <p>11 Q. I guess I'm wondering what an example of a 12 more invasive would be.</p> <p>13 A. So there's two -- maybe this is a semantics 14 thing. But it's a minimally invasive, basically, 15 procedure because you are not making an incision; you 16 are not cutting through muscle to get in there. It 17 isn't so much the invasiveness when you are in. I was 18 trying to explain that it's the pain-inducing things 19 that you do when you are in there.</p> <p>20 So it's minimally invasive no matter what. 21 But within this minimally invasive procedure, you could 22 do things that make it a more painful or more likely to 23 be pain-inducing minimally invasive procedure. And 24 there isn't an exact correlation, by the way. I mean,</p>
<p style="text-align: right;">Page 59</p> <p>1 you are sticking something into somebody. But there are 2 two punctures used and those punctures are typically a 3 quarter of an inch big. They are placed through skin, 4 not put through tissue that tends to produce pain like 5 muscle or bone, that kind of thing. And then so the 6 fact there's no real incision is part of it. That's 7 what makes arthroscopic surgery minimally invasive as a 8 broad category. Beyond that, as I described earlier, it 9 kind of depends what you do with the scope once you are 10 in there. And as I elaborated on in some detail before, 11 there was very, very little done with the scope when he 12 was in there. And in particular he didn't cut, 13 traumatize, affect, act on any tissue that even has 14 nerve endings except for the fact that moving the scope 15 in the knee, you bump up into the synovial a little bit. 16 So it's a minimally invasive procedure to begin with and 17 his was way toward the most minimally invasive spectrum 18 of arthroscopic procedures.</p> <p>19 Q. So just to make sure I'm understanding -- I 20 think I do -- all scopes, basically, are minimally 21 invasive by the fact that it's arthroscopic, but there's 22 a range of invasiveness further within that minimal 23 range that different procedures can have?</p> <p>24 A. Correct.</p>	<p style="text-align: right;">Page 61</p> <p>1 people have a spectrum of pain for similar procedures 2 for reasons unknown. However, I think the essence of 3 what you are asking is what could have made it more 4 painful, to what I referred to earlier. For example, a 5 microfracture, which is something at least I see fairly 6 often. It's a weird name, but you poke little holes in 7 the bone, drill holes in the bone that allow stem cells 8 to grow new cartilage. So then you are drilling in the 9 bone; that tends to hurt more. If you have a peripheral 10 meniscal tear -- so the central part of the meniscus 11 where his was shaved is very easy to access 12 arthroscopically. You put a little shaver in and the 13 shaver goes up against that edge and you don't have to 14 torque the knee.</p> <p>15 One of the things that can make a procedure 16 painful is if you have to get closer to the periphery of 17 a joint in order to get the instrument there without 18 damaging the articular cartilage, you have to open up 19 the joint. That involves stretching the ligament. It's 20 not that big a deal, but it tends to hurt more because 21 you are torquing the knee. For what he did, there's 22 really no torquing of the knee involved. If you do a 23 synovectomy where you are cleaning out a lot of 24 synovium -- synovium is reasonably heavily innervated</p>

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<p>1 and that tends to hurt more.</p> <p>2 So he could have had done a microfracture,</p> <p>3 could have done a synovectomy, could have done something</p> <p>4 that involved torquing the knees more. Sometimes people</p> <p>5 even trim a little -- I don't -- but the medial</p> <p>6 collateral ligament to open the knee more is your -- you</p> <p>7 know, ACL reconstruction is arthroscopic, but it's --</p> <p>8 you do all kinds of stuff. You do -- we cut bone in the</p> <p>9 notch; we shave the ligament ends. Ligaments are</p> <p>10 heavily innervated. That wasn't done there.</p> <p>11 So what else? There's a thing called a</p> <p>12 lateral retinacular release which is done</p> <p>13 arthroscopically and you cut the retinaculum to free up</p> <p>14 the patella. So the same little punctures, but you're</p> <p>15 cutting the heavily innervated tissue. That tends to</p> <p>16 hurt more.</p> <p>17 Those are most of the things that could be</p> <p>18 done to make it -- that would be a more pain-inducing,</p> <p>19 all else equal, minimally invasive procedure that was</p> <p>20 not done in this case.</p> <p>21 Q. Thank you. That's really helpful.</p> <p>22 So the invasiveness of various arthroscopic</p> <p>23 procedures can vary?</p> <p>24 A. I don't mean to play semantics.</p>	<p>Page 62</p> <p>1 can be interchanged.</p> <p>2 So the instrument typically would be a shaver,</p> <p>3 which was used in this case to shave down the meniscus,</p> <p>4 a little grabbing instrument, which was used in his case</p> <p>5 presumably -- he doesn't say exactly, but that's how you</p> <p>6 do it -- to remove the little loose body; it's a little</p> <p>7 hard piece in there. So the shaver is commonly used. A</p> <p>8 grabber may be used. There are little biting</p> <p>9 instruments.</p> <p>10 But what I was doing for the meniscectomy I did</p> <p>11 today, which was more of a meniscectomy where you bite</p> <p>12 pieces of the meniscus which weren't used in his case,</p> <p>13 there can be chondral picks which are used for a</p> <p>14 microfracture, or pins which are used to drill holes in</p> <p>15 bone can be used. There's a cutting instrument that --</p> <p>16 it's a bipolar, unipolar cutting device that can be used</p> <p>17 to cut tissue, for example, for the lateral release that</p> <p>18 I mentioned before or if you are cutting adhesions. So</p> <p>19 those are the tools that are mostly used.</p> <p>20 Q. So there are two punctures and you could say</p> <p>21 one is essentially for a camera more or less for</p> <p>22 visuals, and the second is the tool that's actually</p> <p>23 being used to operate upon the knee?</p> <p>24 A. That's correct. But they tend to be</p>	<p>Page 64</p>
<p>1 Q. I don't either.</p> <p>2 A. I probably wouldn't say the invasiveness; I</p> <p>3 would say the painfulness.</p> <p>4 Q. The painfulness, okay.</p> <p>5 A. Or the aggressiveness, maybe. I don't know.</p> <p>6 The invasiveness just refers to the fact that you are</p> <p>7 just sticking the scope in and not cutting the knee</p> <p>8 open.</p> <p>9 Q. You know, maybe it would be helpful if you</p> <p>10 could describe the basics of an arthroscopic surgery,</p> <p>11 what the scope is, and, you know, how that occurs.</p> <p>12 A. The scope is, generally for a knee, a</p> <p>13 4-millimeter in diameter operating telescope attached to</p> <p>14 a fiberoptic light source. And the scope is positioned</p> <p>15 within a sheath. So generally speaking -- and it was in</p> <p>16 this case -- two small punctures are made in the front</p> <p>17 of the knee adjacent to the tendon in the front of the</p> <p>18 knee so you don't puncture the tendon. And the scope is</p> <p>19 inserted into the knee, the scope is attached to a</p> <p>20 device, generally, that pumps water through the scope</p> <p>21 that inflates the knee with fluid. And then the</p> <p>22 fiberoptic light source is -- the system is fluid-based</p> <p>23 to produce a picture in this fluid medium. Then through</p> <p>24 the other puncture, instruments are put in. And they</p>	<p>Page 63</p> <p>1 interchangable. So you put the camera in the one; you</p> <p>2 put the instruments in the other sometimes. As I just</p> <p>3 did recently, you put the camera in the other and put</p> <p>4 the instruments in the one to get a better look. But</p> <p>5 that's correct.</p> <p>6 Q. Sure. I guess at any given time one is doing</p> <p>7 one role?</p> <p>8 A. Right. And sometimes you will make an extra</p> <p>9 one too if you need to see something better.</p> <p>10 Q. Okay. Mr. Burton had two punctures; is that</p> <p>11 correct?</p> <p>12 A. Yes.</p> <p>13 Q. Okay. In your report -- I'm trying to find</p> <p>14 exactly where this is. Right in the second paragraph</p> <p>15 there under Discussion, Mr. Burton had a minor</p> <p>16 arthroscopy, no incision, knee procedure performed by</p> <p>17 Samuel Chmell, M.D. Would you define minor arthroscopic</p> <p>18 procedure as -- you used "minimally invasive" earlier.</p> <p>19 Let me rephrase that.</p> <p>20 How would you define minor arthroscopic</p> <p>21 procedure?</p> <p>22 A. So "minor" is to some degree redundant with</p> <p>23 arthroscopic. In his case it also applies because what</p> <p>24 was done in the knee was minor as well.</p>	<p>Page 65</p>

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1	Q. Okay. And you say in this point that there 2 was no incision involved. But we have just discussed 3 that there were two punctures you used on each side of 4 the knee to allow instruments into the knee.	1	A. Sure. Number 1, right knee arthroscopy. 2 Number 2, partial lateral meniscectomy. Number 3, 3 chondroplasty. Number 4, removal of loose bodies.
5	A. Right.	4	Q. Could you read the pre- and postoperative 5 diagnoses as well?
6	Q. So when you say there's no incision involved, 7 what do you mean?	6	A. Preoperative diagnosis, right knee lateral 7 meniscal tear. Postoperative diagnosis, right knee 8 partial lateral meniscal tear -- number 1, sorry. 9 Number 2, chondral defect 6 millimeters by 10 10 millimeters of the medial femoral condyle as well as 11 some small loose bodies.
12	A. Oh, I mean -- I don't know -- maybe it's us 13 being euphemistic. That's what we kind of tend to say 14 in this business. We say it's no incision because you 15 are puncturing and you're not using a knife to cut 16 longitudinally. But you could -- technically it's 17 accurate to call those tiny incisions.	12	Q. And if you turn to the next page, I would 13 describe it, I suppose, as a narrative of the procedure 14 that was performed; is that fair?
18	MR. O'HARA: And could you hand me the next 19 exhibit?	15	A. Yes.
20	(WHEREUPON, the document was tendered 21 to Counsel.)	16	Q. And so in your report, you say that the 22 procedure involved a minor debridement, comma, shaving, 23 comma, of his cartilage; is that correct?
24	BY MR. O'HARA: Q. Showing you what I am marking as Exhibit 3, UIC1 through 69. And these are medical records provided by the University of Illinois at Chicago Medical Center.	19	I'm sorry to make you flip between papers.
1	(WHEREUPON, a certain document was 2 marked Plaintiff's Deposition 3 Exhibit No. 3, for identification, 4 as of 01/04/2018.)	20	A. Yes.
5	BY MR. O'HARA: Q. Doctor, do these records look familiar?	21	Q. The procedure also involved two entrances to 22 the knee; is that right?
6	A. Well, let's see.	23	A. Yes.
7	Q. I have a stapled copy if that would be more 8 convenient for you.	24	Q. And the performance of a diagnostic scope?
9	A. No, this is fine.	1	A. Yes.
10	Q. Okay.	2	Q. Could you describe what that is?
11	A. Yeah. I mean, they are parts of the medical 12 record. I don't know that I remember every page, but... 13 Does that answer your question?	3	A. Sure. One puts the scope into the knee and 4 then looks at the various compartments of the knee to 5 assess the pathology.
14	Q. Yes. If you turn to page Bates-stamped UIC15, 15 which, in the middle bottom, is page 7 of 62.	6	Q. And the knee was also entered with a probe?
16	A. Yes.	7	A. Probably.
17	Q. This is the operative report?	8	Q. Would the probe -- is that part of, I guess, 9 the, quote, camera side or the tool side?
18	A. Right.	10	A. Tool side.
19	Q. Attending was Samuel Chmell. And could you -- 20 Do you see where it says title of procedures performed?	11	Q. And what is the probe used for?
21	A. Yes.	12	A. The probe is used to pull on things. It's a 13 slender piece of metal that at the end has a bent tip, 14 maybe 3, 4 millimeters long. So one puts it, for 15 example, on a meniscus to pull and see if there's a 16 tear, that kind of thing.
22	Q. Could you read off those four procedures, 23 please?	17	Q. And so the knee was entered with a shaver too?
24		18	A. Yes, I think. Yes.
		19	Q. And the lateral compartment was -- is it 20 debrided or debried?
		21	A. Usually debrided, but either is okay.
		22	Q. And the lateral compartment was debried?
		23	A. Yes.
		24	Q. What's the lateral compartment?

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<p style="text-align: right;">Page 70</p> <p>1 A. So the lateral compartment is the left side of 2 the left knee, right side of the right knee. The outer 3 part of the knee.</p> <p>4 Q. So when you say the part, is it cartilage? Is 5 it bone? Is it a ligament that's actually -- what would 6 have been shaving up against?</p> <p>7 A. So you are not asking about the compartment; 8 you are asking what he was shaving?</p> <p>9 Q. Well, it says the lateral compartment was 10 debried, I believe, in the report, the surgeon's 11 report.</p> <p>12 A. Yeah. That's maybe not the -- with all due 13 respect to the doctor -- maybe not the most specific 14 terminology because you don't -- again, I don't mean to 15 split hairs, but one doesn't actually debride a 16 compartment; one debrides tissue. So what he did, 17 putting all this together, is he debrided the lateral 18 meniscus. Maybe that's what he meant to say or maybe 19 they didn't hear it right with the dictation. So he 20 debrided the lateral meniscus with the shaver. And 21 that's what I was referring to. The debridement of the 22 meniscus is a less invasive meniscectomy than the usual 23 situation where you are actually biting the pieces off. 24 And you only do that if it's just hardly torn at all.</p>	<p style="text-align: right;">Page 72</p> <p>1 Q. So he was shaving cartilage on the end of the 2 femur?</p> <p>3 A. Right.</p> <p>4 Q. Okay.</p> <p>5 A. Two different kinds of cartilage. It gets 6 confusing. That's articular cartilage on the medial 7 femoral condyle and then it was meniscal cartilage in 8 the lateral part.</p> <p>9 Q. Is there a significance between the two 10 differences from a surgical standpoint?</p> <p>11 A. Well, yeah. I mean, they do different things. 12 The one is a coating. The articular cartilage is what 13 coats the bone like Teflon on a frying pan. So you are 14 saying from the surgical point of view. The other, 15 meniscus, is a wedge-shaped shock absorber. In this 16 case there really wasn't because he shaved them both. 17 In general, you know, I would say well over 18 90 percent of the menisectomies that one does also 19 involve biting instruments because there's flaps of 20 tissue. So surgically -- I think that's your 21 question -- generally one is using biting instruments as 22 well as the shaver on the meniscus where there's usually 23 only a shaver on articular cartilage.</p> <p>24 Q. Is there a difference in the pain that can be</p>
<p style="text-align: right;">Page 71</p> <p>1 So he debrided the meniscus with the shaver. He also 2 debrided elsewhere, but I don't want to get ahead of 3 you. I think that's what he was trying to say.</p> <p>4 Q. Okay. Understood.</p> <p>5 I believe it also said he debrided the 6 ligamentum mucosum?</p> <p>7 A. Yes. That's -- it's not actually a ligament. 8 It's called that because people -- you can be fooled. 9 It looks like a ligament, but it's not. It's synovium. 10 Synovium is the lining tissue of the knee. And when you 11 go into the knee, sometimes it just kind of gets in the 12 way. So it's just some spongy, filmy, fatty tissue that 13 you debride, not therapeutically, but so that you can 14 see.</p> <p>15 Q. Okay. And then it says chondroplasty 16 performed on medial compartment to remove free cartilage 17 flap. Could you describe that process?</p> <p>18 A. Yeah. So, again, he could have been a little 19 more specific as to terminology. But what he did and 20 what he meant was that on the medial femoral condyle, 21 which is the end of the femur on the inner part, the 22 articular cartilage that coats the bone had some damage. 23 So there tends to be edges that are kind of loose, 24 little fronds of tissue. So we shave those.</p>	<p style="text-align: right;">Page 73</p> <p>1 produced by working on those types of cartilage or would 2 it be no pain whatsoever for both?</p> <p>3 A. So the shaving of the cartilage itself on the 4 articular cartilage is 100 percent pain-free. Not to 5 say the scope is 100 percent pain-free; but shaving that 6 cartilage, there are no nerve endings. If you drill the 7 bone underneath, there are nerve endings, but none in 8 the articular cartilage. The meniscus -- the meniscus 9 has no nervling endings either through most of its 10 distance. Far in its periphery, it -- and no blood 11 vessels either, by the way. There are some blood 12 vessels, some nerve endings. So if you are shaving 13 it -- by definition, it's a central part which is a very 14 thin border. So that part, number one, has no nerve 15 ending. So there's no pain from doing that. And, 16 number two, as I kind of alluded to earlier, sometimes 17 you have to kind of torque the knee to get into the 18 peripheral part. So you can maybe get some pain from 19 that. But you don't have to do that with what he did. 20 So those two things should have been -- just those parts 21 of the procedure should have been completely painless.</p> <p>22 Q. During the scope, perhaps one like this, is it 23 possible for the instruments in the knee to come into 24 contact with the parts of meniscus that have nerve</p>

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<p>1 endings?</p> <p>2 A. So there are no nerve endings on the surface 3 of it as best we know. So if you brush against it, it 4 wouldn't be a problem. And there aren't even many nerve 5 endings where there are nerve endings. But for what he 6 did, no. He was just at the central border of it. You 7 have to get all the way to the periphery for that to 8 happen.</p> <p>9 Q. Okay. Loose bodies finally were then removed?</p> <p>10 A. Right.</p> <p>11 Q. As part of the surgery? Can you describe that process?</p> <p>13 A. Sure. They look like little white marbles 14 floating in the knee. And one takes a little grabbing 15 instrument and just kind of grabs it and then you just 16 pull it out. So there's no cutting. They just float 17 and you just grab it and you pull it out the little 18 portal.</p> <p>19 Q. And what are they typically? What are they made of?</p> <p>21 A. Well, they are typically -- So, you know, he 22 had that cartilage defect on the medial femoral condyle, 23 articular cartilage. So what can happen and probably 24 did in this case is that a piece of cartilage will kind</p>	<p>Page 74</p> <p>1 description of procedure. Is it on that page?</p> <p>2 Q. It should be on the description of procedure 3 page, yes. Actually, it's on the next page, page 17.</p> <p>4 It says, Loose bodies were noted in the lateral gutter 5 which were also removed and then the arthroscopic 6 clipper was removed.</p> <p>7 A. Let's see. Which were also removed. So I've 8 got to tell you, there's no device that I know of that's 9 called a clipper. I have to tell you, we dictate these 10 things and the transcriptionist can't always hear. So 11 clipper -- I mean, there's a shaver, but typically -- 12 which were also removed. So then the arthroscopic -- 13 No, actually, that wouldn't have been the shaver. The 14 arthroscopic clipper -- it must -- I mean, so would have 15 taken place there is you take the grabber, you pull out 16 the loose body, and then the only thing left is the 17 scope and you take out the scope. So what that had to 18 be was the arthroscopic instrument. It had to be the 19 scope. There's nothing else there. There's no clipper.</p> <p>20 Q. Okay. I will trust your judgment on that.</p> <p>21 And then, finally, the wound was sealed with 22 sutures; is that correct?</p> <p>23 A. Yes.</p> <p>24 Q. Okay. Turning back to your report, in the</p>
<p>1 of flake off and it can be dissolved and usually is. 2 But in some people, rather than dissolving, for whatever 3 reason, it becomes kind of hardened and it's like a 4 little marble and they just kind of float in the knee. 5 So they are made initially of cartilage. They can 6 calcify a little sometimes -- you can see them on 7 x-rays -- sometimes not. So they are typically made of 8 cartilage and inside they can have like a little scar 9 tissue, you know. So that's what they are.</p> <p>10 Q. And what typically would cause one to have 11 loose bodies floating in the knee?</p> <p>12 A. Well, typically the articular cartilage will 13 flake off. And why does that happen? It can be a 14 wear-and-tear thing with arthritis. He had some 15 arthritis in his knee. And so the question that we 16 wonder is why doesn't the stuff just dissolve. You 17 know, why in some people does it form a little hard 18 marble and in other people it dissolves. And nobody 19 really knows.</p> <p>20 Q. Interesting.</p> <p>21 The report then goes on to say that the 22 clipper was removed from the knee. Do you know what 23 they would be referring to with the clipper?</p> <p>24 A. Can you tell me where that is? I'm under</p>	<p>Page 75</p> <p>1 middle of that same second paragraph there under 2 Discussion, you say that the only pain, if any, produced 3 from the procedure is from the arthroscope, a 4 4-millimeter operating telescope being introduced into 5 the knee, and the knee being inflated with fluid for 6 visualization; is that correct?</p> <p>7 A. Yes.</p> <p>8 Q. So the introduction of the arthroscope itself 9 can cause pain?</p> <p>10 A. Yes.</p> <p>11 Q. And the introduction of fluid can cause pain 12 as well?</p> <p>13 A. Well, the truth is nobody knows. But, you 14 know, maybe so. Maybe inflating the knee, although it's 15 not inflated for very long.</p> <p>16 Q. And it's your opinion that those were the only 17 causes of pain Mr. Burton could have experienced from 18 these procedures?</p> <p>19 A. Yes.</p> <p>20 Q. So none of the other operations we discussed 21 could have caused pain?</p> <p>22 MR. LOMBARDO: Object to form.</p> <p>23 BY THE WITNESS:</p> <p>24 A. None of the other parts of the operation that</p>

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<p style="text-align: right;">Page 78</p> <p>1 we discussed -- like shaving cartilage cannot cause 2 pain, articular cartilage. Shaving the central border 3 of a meniscus cannot cause pain. Removing a loose body 4 can cause pain if you get a really big one and you have 5 to enlarge the puncture to get it out -- but there's no 6 evidence that that happened -- cannot cause pain. And 7 then the diagnostic arthroscopy, I mean, I guess if you 8 are really rough, but the proper technique for this is 9 to not have the scope bouncing around in the knee. And 10 I'm sure he's a good surgeon. So right. I mean, you 11 know, like I say, shaving the ligamentum mucosa, that's 12 innervated maybe a little.</p> <p>Q. So the shaving of the ligamentum mucosa could have been an additional source of pain?</p> <p>A. Yeah, maybe a little.</p> <p>Q. Okay. Can an arthroscopic procedure cause increased pain in patients with arthritis?</p> <p>A. Relative to those without arthritis?</p> <p>Q. Correct.</p> <p>A. Well, all else equal, the same procedure but one is arthritic and one isn't, there's no evidence that that an arthritic knee would experience more pain than a nonarthritic knee.</p> <p>Q. What about the manipulation of the knee during surgery?</p>	<p style="text-align: right;">Page 80</p> <p>1 speculation. 2 BY THE WITNESS: 3 A. The way you would manipulate it is -- 4 depending -- there's different setups, but there's a 5 bolster -- there's stabilization of the thigh in one 6 fashion or another. And then you kind of stretch the 7 inner part of the knee to move it out this way to get 8 way to the periphery (Indicating). So it's kind of hard 9 to do that. And when you do it, you have to stick the 10 scope into a very tight space and there's some risk that 11 you can damage cartilage. My point being, you don't 12 just do this for no reason. You do it if you really 13 have to do it.</p> <p>14 So no. I mean, there's no way in heck -- 15 unless he had a resident that he was just trying to show 16 something gratuitously, you know. But, no, not for 17 this.</p> <p>Q. Okay. You go on to state to continue in your report that to the extent there's any pain associated with this procedure, it is minor; is that correct?</p> <p>A. Yes.</p> <p>Q. And when you say that, do you mean pain during surgery or after surgery would be minor?</p> <p>A. Well, the only pain you would feel would be</p>
<p style="text-align: right;">Page 79</p> <p>1 A. Yeah. I mean, it is hard to know there for 2 sure either. But on theoretical grounds, if you are 3 cranking on the knee for a long time, you would think 4 that might cause pain. I don't know for sure that it 5 does, but in theory it could. But, again, this was not 6 a knee where you needed to do that. You know, and even 7 when you do it, you really can't do it too aggressively. 8 So I don't think in his case -- you know, the scope was 9 put in; he took out the loose body; he shaved this; he 10 shaved that.</p> <p>11 See, most of the procedure, the knee just 12 hangs down and you stick the scope in. We have an 13 assistant -- at least I do -- and for some of these 14 cases the assistant does almost nothing, you know. So I 15 have an assistant. And if I do need to open the knee to 16 get to the periphery -- and sometimes you don't need to, 17 but, you know, this would have just been one where you 18 stick the scope in and you move it around a little and 19 you take the stuff and you shave a little bit, so...</p> <p>20 Q. Is it possible that Dr. Chmell or other people in the room like their assistants did manipulate the knee during the surgery?</p> <p>21 MR. LOMBARDO: Objection. Form. Calls for</p>	<p style="text-align: right;">Page 81</p> <p>1 after because you are asleep. But I don't know. Who 2 knows what you feel when you are unconscious, right? 3 But is that what you mean?</p> <p>Q. Well, I guess my question is: It would be painful during the procedure if one was not under general anesthesia, correct?</p> <p>MR. LOMBARDO: Object to form.</p> <p>BY THE WITNESS:</p> <p>A. That's like a metaphysical question. Is it painful if you can't feel pain, right? Yeah, if you didn't have the anesthetic, it would hurt.</p> <p>Q. Right. Why are patients put under general anesthesia?</p> <p>A. It would certainly be painful if you weren't asleep.</p> <p>Q. Okay. Isn't it true that some patients are only given local anesthesia in arthroscopic procedures?</p> <p>A. No. There's two ways you can do it. You can -- most people are given general because it's quick and easy and it's not a very deep general. You could do it with regional anesthetic, which would be a spinal or an epidural or a combination of both. It is theoretically possible to do it under local, but nobody does and you wouldn't because -- so the reason you would</p>

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<p>1 use one form of anesthesia would be matter of risk. And 2 if a patient was at high risk for general, you would do 3 a spinal or epidural. But you would not do it because 4 it's ineffective. Secondly, local anesthetics, the 5 -caine anesthetics, lidocaine, Marcaine, are incredibly 6 chondrotoxic. So they kill cartilage cells and they 7 don't recover. So if you put enough stuff in there, you 8 could probably get by doing it, but you would horribly 9 damage cartilage. So nobody does it.</p> <p>10 Q. Okay. In this case Mr. Burton was put under 11 general anesthesia?</p> <p>12 A. I believe so.</p> <p>13 Q. What are the risk factors that would make 14 someone a bad candidate for general anesthesia?</p> <p>15 A. You know, those are fluid and those are things 16 I will leave to the anesthesiologist. These days -- 17 particularly for this because, you know, the risk is to 18 some degree proportional to how much medicine you give 19 people. Because this isn't a very painful procedure, 20 they don't have to give people that much stuff. Usually 21 you almost never use a breathing tube, an endotracheal 22 tube. You use a mask or what's called an LMA. I 23 suppose somebody who was a very -- I don't know, you 24 know, a very bad cardiovascular situation. But, again,</p>	<p>Page 82</p> <p>1 A. Yes. 2 Q. It's stronger than morphine? 3 A. I don't know. You mean equianalgesic doses? 4 Q. Yes. 5 A. I don't know. I would have to look at a 6 chart, maybe. 7 Q. Is Fentanyl ever prescribed for minor pain? 8 A. Well, it's not prescribed period. Right? 9 It's used in -- So there are Fentanyl patches, but 10 Fentanyl is not something you prescribe to an 11 outpatient. 12 Q. What's a -- Intravenous Fentanyl being dosed, 13 what kind of pain is that typically given for? 14 A. So the only time that Fentanyl is commonly 15 used, period, there are people that use Fentanyl pain 16 patches, which absorb through the skin, and it's used in 17 surgery commonly. And it's abused, as you probably 18 know, or maybe you don't read the papers. 19 Q. I've heard. It's horrible. 20 A. But it's not something that -- except for the 21 patches -- and I don't know. Maybe there are people in 22 pain clinics that are giving that stuff out, but it's -- 23 the only time I have exposure to it is perioperatively. 24 Q. What do you mean by perioperatively?</p>	<p>Page 84</p> <p>1 A. Like when putting somebody to sleep, waking 2 them up, that kind of thing. Maybe in recovery. 3 Q. Gotcha. 4 So when it's used correctly in these 5 situations, what type of pain is Fentanyl given for? 6 A. So, first of all, people will use narcotics 7 during a case. And you can kind of overmedicate people 8 because you have their airway controlled -- do you know 9 what I mean? -- in a way that you wouldn't otherwise. 10 So if you are asking would they have given Fentanyl if a 11 patient was only having minor pain at the time of 12 surgery, I don't know. Narcotics are used -- and I'm 13 not an anesthesiologist, so I don't want to get over my 14 head here. But, you know, narcotics are used to kind of 15 make people calm and relaxed and not kind of feel 16 anything in a way that you wouldn't use if you were 17 after surgery where you have to worry about side 18 effects. Does that make sense? 19 Q. So you believe it was used during surgery or 20 after? 21 A. Well, I don't know. When was it? So you can 22 read this, right? I really can't. It's usually -- it's 23 not -- it might be used in the recovery room, I guess. 24 Q. That is my understanding, that this was in the</p>
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<p>1 recovery room.</p> <p>2 A. So why would they be giving Fentanyl if he 3 wasn't in a lot of pain? Maybe he was in a lot of pain 4 and they gave him that. I don't know. Maybe. But, you 5 know, sometimes -- So people wake up from surgery, you 6 have to realize too, sometimes kind of -- and I don't 7 know what happened with him, but kind of obstreperously, 8 as it were, you know. So I don't know. He might have 9 been a little unruly. He might have said that he was in 10 a lot of pain, something like that. You know, so it was 11 probably their perception. And they tend to use big 12 guns more in that setting than you would if a patient 13 were more awake and lucid.</p> <p>14 Q. Is it fair to say that Fentanyl is used to 15 relieve severe pain after surgery?</p> <p>16 A. Does the pain have to be severe to use 17 Fentanyl, I guess, is your question. Is that your 18 question?</p> <p>19 Q. That wasn't quite it. That is a question and 20 you can answer that.</p> <p>21 A. So could it be used to relieve severe pain 22 after surgery? It could. Does the pain have to be 23 severe to use it? I don't know. Maybe, but I don't 24 know. If you use a small enough dose of any of this</p>	<p>Page 86</p> <p>1 Q. Okay. You mentioned you specialized in 2 arthroscopic knee surgery for over 30 years and you 3 performed thousands of arthroscopic knee procedures. 4 What are the procedures you most regularly perform?</p> <p>5 A. So the things I most commonly do, most of my 6 surgical practice is arthroscopic knee and shoulder 7 surgery. And of those -- So it's about half and half. 8 So in the knee, meniscectomy is probably the commonest 9 one. Meniscectomy, microfracture, ACL reconstruction, 10 meniscal repair. Probably those more than anything 11 else.</p> <p>12 Q. Thank you.</p> <p>13 Moving on in your report, just toward the end 14 of this page here, you say, The pain produced for this 15 kind of surgery ranges from negligible with some 16 patients not taking any pain medication at all after 17 surgery --</p> <p>18 A. I'm sorry. Is this on 5?</p> <p>19 Q. BUR5.</p> <p>20 MR. LOMBARDO: The last sentence.</p> <p>21 BY THE WITNESS:</p> <p>22 A. Got it.</p> <p>23 The pain produced --</p> <p>24 Q. Ranges from negligible with some patients not</p>
<p>1 stuff, not necessarily. And people tend to use drugs 2 they are familiar with too. So Fentanyl is something 3 the anesthesiologists use a lot. I don't know how big a 4 dose this was. You know, if you use a small enough dose 5 of anything, it doesn't have to be for severe pain. So 6 I don't know.</p> <p>7 25 milligrams, it says?</p> <p>8 Q. I believe that's my deciphering too.</p> <p>9 Would you say it's fair to say it's commonly 10 used to treat pain?</p> <p>11 A. It's commonly used -- So, again, I don't pay a 12 lot of attention to what they do. They kind of do their 13 thing, and I do the surgery. But Fentanyl is one of the 14 drugs that's used to -- for an induction. I'm not sure. 15 But it's used a lot perioperatively in the process of 16 putting people to sleep, while they are asleep, I guess, 17 shortly after they wake up. So there's a part of the 18 case where the anesthesiologist is in charge of all 19 their pain. And that's in the operating room, in the 20 preop area, in the recovery room. So when they are 21 doing their thing, I mean, they use it.</p> <p>22 As I said, I don't pay a whole lot of 23 attention. I pick them up when they get out of the 24 recovery room and I never use it there.</p>	<p>Page 87</p> <p>1 taking any medication at all after surgery to moderate 2 with some patients taking moderate strength medicines 3 for a period of days.</p> <p>4 So some patients do, in fact, have greater 5 than minor pain following arthroscopic knee surgery?</p> <p>6 A. Yes.</p> <p>7 Q. And when you say moderate strength pain 8 medicines, what do you mean? What are you describing 9 there?</p> <p>10 A. Well, I kind of phrased that strangely. 11 Generally -- so I give most people hydrocodone, but I 12 watch how much they take and I urge them -- and some 13 people don't take it at all, and I tell them -- so I 14 give it to them. But if you take hydrocodone and you 15 are not in pain, that's when people die -- oxycodone 16 too -- because it's a respiratory suppressant. So I 17 give everybody hydrocodone. Some people, just Tramadol. 18 I have some people who don't take anything. Some 19 people, Tylenol. So I would say moderate -- it's kind 20 of funny working -- it isn't so much what the medicine 21 is as how much of it you take.</p> <p>22 Q. What's -- I don't want to use the word 23 "standard," but I suppose I will and we finagle. What's 24 a standard prescription you would give of hydrocodone as</p>

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<p>1 far as dosage and size and how often it's taken?</p> <p>2 MR. LOMBARDO: Object to form. Calls for 3 speculation, incomplete hypothetical.</p> <p>4 Go ahead.</p> <p>5 BY THE WITNESS:</p> <p>6 A. So depending on the patient, and, you know, 7 some patients, I maybe wouldn't. But most of my 8 patients, I give them what's called Norco 10, but it's a 9 scored tablet. So you can take half, so it's a 5. So 10 patients are specifically instructed to take -- to not 11 take anything until they are in pain and then to try a 5 12 and see what happens. And if it makes them loopy, not 13 take any more. If it's about right, then they can take 14 it more and then -- you know, if I do like an ACL 15 reconstruction, which is a bigger procedure, those 16 people will typically need the 10s.</p> <p>17 So I tell people -- So it's a combination of 18 hydrocodone and acetaminophen. And I go to great 19 lengths to tell people, You can just take Tylenol and 20 you can kind of use those too. Some people, I give 21 Tramadol too, for example, which is a weak -- they 22 didn't used to think it's an opioid, but it is now. 23 It's been reclassified, but it's a weak opioid.</p> <p>24 Does that answer your question? I give most</p>	<p>Page 90</p> <p>1 of my patients never finish the prescription.</p> <p>2 Q. Sure. Just as far as what's prescribed.</p> <p>3 A. So at most how much would it be?</p> <p>4 Q. Yeah.</p> <p>5 A. A few days.</p> <p>6 Q. Okay.</p> <p>7 A. And, again, that's in the case where I am in 8 touch with my patients. And so I think Dr. Chmell 9 giving him that many would have been just fine. It is 10 fine, but if he was there to monitor the patient 11 himself.</p> <p>12 Q. I understand.</p> <p>13 You may have actually said this earlier. Do 14 you typically give local anesthetic at the end of a knee 15 arthroscopy?</p> <p>16 A. I don't. I give a little at the beginning. I 17 put a little local in the portals where I put the scope. 18 And, actually, it's a little epinephrine. So it doesn't 19 bleed. But I don't give local for the reasons that I 20 said, actually.</p> <p>21 Q. Are you aware of other doctors who do so as a 22 practice?</p> <p>23 A. So here's the thing, it depends what kind of 24 case you are talking about. So for knee replacements,</p>
<p>1 people hydrocodone, but I tell them to take half a 2 tablet and not to take it very often unless they need 3 to.</p> <p>4 Q. How many tablets would come in one of these 5 prescriptions?</p> <p>6 A. 30.</p> <p>7 Q. And how often if they are experiencing pain 8 are they supposed to take it?</p> <p>9 A. So the maximum they can take, like for an ACL 10 reconstruction --</p> <p>11 Q. Sure.</p> <p>12 A. And I just did an ACL -- she just left here -- 13 who took one per day. But the maximum that you can take 14 is one every three to four hours. And the thing is, 15 though, like I said, you have to titrate the dose to how 16 they are feeling. So if they are dying, you know, they 17 should take more. I don't want to be torturing people. 18 But if you are calm and you take this, it's a 19 respiratory suppressant and it's very dangerous.</p> <p>20 Q. So with 30 pills, I guess, and the maximum you 21 would be taking is, you know, every, let's say, three to 22 four hours, that would represent several days' worth of 23 hydrocodone; is that correct?</p> <p>24 A. So for arthroscopic procedures like this, most</p>	<p>Page 91</p> <p>1 there are all kinds of protocols -- and I don't do knee 2 replacements -- there are all kinds of protocols where 3 you can do that stuff. As I mentioned, there are pain 4 pumps that exist where people will give local. So not 5 to throw stones, but there's a horrible complication of 6 arthroscopic surgery called -- well, the cartilage goes 7 away; all the cartilage dissolves after the procedure. 8 And this was correlated -- so every once in a while, 9 you -- it's never happened to me, thank God -- you do 30 10 knee scopes, 30 shoulder scopes, and then one person 11 comes in -- a healthy young person comes in and their 12 shoulder is gone, totally gone, needs a shoulder 13 replacement, 20 years old, whatever, and this was 14 correlated to local anesthetics from pain pumps. So I 15 would never use one. I would never use one in a joint 16 like this. I think they still exist. And you can use 17 morphine, which is probably okay, I guess. I mean, 18 don't know anybody, though, who uses pain pump for a 19 knee scope.</p> <p>20 I mean -- and I will tell you, so we -- so the 21 bigger knee -- the most knee scopes that deal with the 22 menisci are the articular cartilage. The big step-off 23 tends to be ligament surgery, like ACL. And, again, we 24 had a whole section -- we have like four chapters on</p>

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<p style="text-align: right;">Page 94</p> <p>1 that and we reviewed all the literature. And what 2 people will do is use nerve blocks, but I don't know 3 anybody who uses a pain -- I'm not saying it's wrong, 4 but I don't know anybody who uses a pain pump. There 5 are -- so people use pain pumps around a nerve. So they 6 are commonly used there. So if you do a nerve block -- 7 which I don't, but some people do -- you inject the 8 nerve and it numbs it for like eight hours. So you can 9 put a pump in to have a continuous infusion of 10 anesthetic to the nerve. Those are used by some people. 11 But a pain pump with a nonprosthetic procedure, where 12 you are not -- if you put lidocaine into a metal knee, 13 it doesn't matter. But if you put it in articular 14 cartilage, it can matter. So people using a pain pump 15 to pump like a local anesthetic into a knee after an 16 arthroscopic meniscectomy, I would have to say to you I 17 don't think that's done very much.</p> <p>18 Q. Okay. Are there other forms, besides the pain 19 pump, of local anesthetic that might be given after a 20 surgery?</p> <p>21 A. There are people -- and I sort of do this too, 22 like if you -- there are people that would inject the 23 incision in the skin with local.</p> <p>24 Q. Sure.</p>	<p style="text-align: right;">Page 96</p> <p>1 I mishear you? 2 A. You mean like the punctures? 3 Q. Yes. 4 A. Yeah. So you can put a little local right 5 where you puncture the skin. I do, in fact. And I 6 actually don't do it for the analgesia. And some cases 7 I don't do it at all because people are allergic or 8 whatever. And the only reason I do, actually, is 9 because it's a little epinephrine. So when you puncture 10 the skin, it can bleed a little bit. And the local, the 11 Marcaine that I use, that's just like 3 CCs total has 12 some epinephrine in it. So when I put it in, it just 13 doesn't bleed as much when I put in the scope. It's 14 really not a big deal. So that's a little in the skin. 15 That, by the way, wears off in a couple of hours.</p> <p>16 Q. Okay. There's no indication in the record 17 that Mr. Burton received any type of local anesthetic; 18 is that correct?</p> <p>19 A. Let's see. He might have said. I didn't 20 check that. Is this the unstapled one the operative 21 note?</p> <p>22 Q. UIC16, I believe, is the operative note.</p> <p>23 A. No, it doesn't say. And I guess I should look 24 at the end too. Let's see. Yeah.</p>
<p style="text-align: right;">Page 95</p> <p>1 A. There isn't much of an incision here; there's 2 just two little punctures -- not a whole lot to numb up, 3 you know -- and other people who would put a lot of, 4 like, Marcaine into the knee after the procedure, maybe. 5 I don't know.</p> <p>6 But, see, the other thing with that, by the 7 way, and one of the reasons I don't do it and don't do 8 nerve blocks, is there is a well-documented rebound 9 effect. So even with nerve blocks, when you numb nerves 10 when they come back, they come back stronger. So there 11 have been so-called VAS studies. The VAS is a 12 (unintelligible) vein. And the day of surgery, people 13 will have less if you gussy them up with stuff to make 14 it hurt less afterward, but the next day they have more 15 pain. So that's been true of nerve blocks and pain 16 pumps in general.</p> <p>17 So other local -- there are people, I think, 18 for total knees who are putting -- injecting things 19 around various nerves, like nerve blocks afterward, I 20 guess. But, I mean, jeez, nobody would do that for like 21 a little knee scope for a meniscus.</p> <p>22 Q. Gotcha.</p> <p>23 What was the smaller thing you maybe described 24 putting injection into the site of the incision? Or did</p>	<p style="text-align: right;">Page 97</p> <p>1 Q. Moving on in your report, BUR6, the first full 2 paragraph, that sentence there says, Mr. Burton was 3 prescribed Norco, hydrocodone, by his surgeon after 4 surgery as a precaution in case he had more pain than 5 usual; is that correct?</p> <p>6 A. Yes.</p> <p>7 Q. So you described you regularly prescribe 8 hydrocodone to patients following knee arthroscopies?</p> <p>9 A. Yes.</p> <p>10 Q. So some patients can experience pain that does 11 require treatment with hydrocodone?</p> <p>12 A. Or the equivalent, but yes.</p> <p>13 Q. Would you say that hydrocodone is prescribed 14 for more than minor pain, for greater than minor pain?</p> <p>15 A. Well, you could say that. It's a matter of 16 context, though, right? So it's more than minor pain. 17 You get -- walk around the house stubbing your toe. 18 But, yeah, sure, you could say that.</p> <p>19 Q. Okay. Where in the medical records does 20 Dr. Chmell state that he prescribed Norco as a 21 precaution?</p> <p>22 A. It's inherently a precaution. I don't -- No 23 surgeon would say I prescribed this as a precaution in 24 case the patient had more pain than usual. You would</p>

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<p style="text-align: right;">Page 98</p> <p>1 never do it. I don't do it. But it's inherently 2 part -- He is a good doctor. I'm sure he talked to the 3 family. And what you would tell the family is, you 4 would say -- every surgeon would do this. You would 5 say, I don't think it's a very painful procedure; he may 6 have very little pain; he might not need pain medicine; 7 he may get by with just ice or Tylenol. If, however, he 8 has severe pain beyond what ice or Tylenol will take 9 care of or seems to be in a lot of pain or moderate pain 10 or whatever, if he seems to be in more pain, then you 11 should give him that.</p> <p>12 So it's inherently -- I mean, you know, 13 because it's a PRN drug. You have to understand that's 14 what PRN means, right? PRN means as needed. So if you 15 don't need it, you don't take it. If it weren't PRN, it 16 would be different, like if somebody were on a 17 respirator or something, right? Then you are just 18 saying, I'm going to give this to you no matter what. 19 You don't do that very often. You certainly would never 20 do it here.</p> <p>21 Q. So your description of the prescription as a 22 precaution is based off your experience and knowledge of 23 the practice?</p> <p>24 A. It's what every orthopedic surgeon alive who's</p>	<p style="text-align: right;">Page 100</p> <p>1 it and I will say it might hurt a little more than 2 usual, but better than that to OD.</p> <p>3 Q. Would you say you prescribe hydrocodone as a 4 precaution in most of your knee arthroscopy patients?</p> <p>5 A. Yes, for sure.</p> <p>6 MR. O'HARA: I think the DVD is going to end in a 7 few minutes, so we will go shortly and then take a quick 8 break.</p> <p>9 About how long does it take to change?</p> <p>10 THE VIDEOGRAPHER: Two minutes.</p> <p>11 MR. O'HARA: Maybe we'll take a five-minute break.</p> <p>12 Is that okay?</p> <p>13 THE WITNESS: Yeah.</p> <p>14 THE VIDEOGRAPHER: Off the record at 6:21 p.m. (WHEREUPON, a brief break was had.)</p> <p>15 THE VIDEOGRAPHER: This begins disc number 2. Back on the record at 6:31 p.m.</p> <p>16 MR. LOMBARDO: Before we start, we tendered the notes that Dr. Prodromos was using during his deposition. It's our position that generally notes of this nature would be subject to privilege; however, because he is utilizing those notes during the deposition, we have tendered them.</p>
<p style="text-align: right;">Page 99</p> <p>1 competent does. It's what every doctor does. It's what 2 any health practitioner does. Anytime you are giving 3 anybody pain medicine, they are essentially, to use your 4 wording, precautionary, in case you have pain. To do 5 otherwise is to -- that's how you get complications. Do 6 you know what I mean? You would never say just take it. 7 You would say take it only if.</p> <p>8 Q. So it's prescribed because there's a 9 possibility that the patient would experience 10 significant pain?</p> <p>11 A. Yes.</p> <p>12 Q. Okay.</p> <p>13 A. And the other thing, by the way, that enters 14 into this these days is that -- sort of the law of 15 unintended consequences -- we can no longer phone in 16 hydrocodone. So you almost have to overprescribe a 17 little because if the patient has severe pain in the 18 middle of the night beyond what you would expect or pain 19 more than appropriate, you really have no recourse. You 20 know what I mean? So you almost -- you almost have to 21 give them the strongest thing that they could possibly 22 need and just make sure you talk to them. And then if 23 you have a patient who's had substance issues, then I 24 just don't do it. And there are people where I won't do</p>	<p style="text-align: right;">Page 101</p> <p>1 Go ahead, Counsel.</p> <p>2 BY MR. O'HARA:</p> <p>3 Q. Doctor, I just want to remind you that you are 4 still under oath.</p> <p>5 A. Yes.</p> <p>6 Q. Terrific.</p> <p>7 Norco comes in 5- and 10-milligram dosages; is 8 that correct?</p> <p>9 A. Yes.</p> <p>10 Q. Are there any other dosages it comes in?</p> <p>11 A. There may be. I'm not sure. Those are the 12 two that I'm familiar with.</p> <p>13 Q. And Mr. Burton was prescribed 50 doses of 14 10-milligram Norco; is that right?</p> <p>15 A. I think so.</p> <p>16 Q. It was prescribed at Q6H?</p> <p>17 A. I'm not sure. Maybe.</p> <p>18 Q. Why don't you look at your records I believe 19 it's -- you can use UIC65.</p> <p>20 A. That sounds reasonable, so I'll take your word 21 for it.</p> <p>22 Q. What does Q6H mean?</p> <p>23 A. Every 6 hours.</p> <p>24 Q. So 50 tabs at Q6H, if he were to take all of</p>

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<p>1 them, that would be enough painkillers for over 12 days; 2 is that correct? 3 A. For this? 4 Q. If he took them every six hours. 5 A. Yes. So it was one Q6, right? So that's four 6 into 50. So yeah, yes, yes, yes, yes, yes. 7 Q. I think it's about 12. 8 You state that the actual type and dosage of 9 pain medicine to be administered is always evaluated as 10 a function of the amount of pain the patient has 11 experienced after surgery and is adjusted downward if 12 pain is not severe; is that correct? 13 A. Yes. 14 Q. But it's true that Mr. Burton was experiencing 15 pain of 8 out of 10 following surgery, correct? 16 A. I read 5 out of 10. 17 Q. If you go to the recovery room. Particularly 18 in the recovery room. 19 A. Oh, maybe in the recovery room, maybe in 20 recovery. 21 Q. Okay. And you state that in Mr. Burton's 22 case, the pain was found to be minor on the night of 23 surgery in documented medical records. 24 A. Counsel, forgive me, I just want to make sure</p>	<p>1 Q. 3:55 p.m., that's about the time or not long 2 after he was brought back from surgery; is that correct? 3 A. Yes. 4 Q. So at the time he had been dosed with several 5 narcotic painkillers at the surgery site; is that 6 correct? 7 A. I don't know. What time were they given? 8 Q. Strike that. 9 Following his surgery, he was given several 10 doses of Fentanyl and one of hydrocodone; is that 11 correct? 12 A. Yeah. That was 12-something, wasn't it? I 13 don't remember. 14 Q. We can check. 15 A. I know you pointed out that page before. 16 Q. Now I forget what number it was. 17 MR. LOMBARDO: It was UIC52. 18 MR. O'HARA: Thank you, Joe. 19 BY THE WITNESS: 20 A. So they look like 12s to me, 12-something, 21 12:40, 12:50. 22 MR. LOMBARDO: It looks like 12:15, 12:25, 12:45, 23 and 12:55 to me. 24</p>
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<p>1 I'm following you. 2 Q. Not at all. I apologize. 3 A. Is this Exhibit 1? 4 Q. This is Exhibit 1. This is your report. 5 A. And this is page 6? 6 Q. I believe so. 7 MR. LOMBARDO: First full paragraph on the page. 8 BY THE WITNESS: 9 A. Got it. 10 So indeed Mr. Burton's case. Right, I think 11 that's where you are. 12 Q. You said his pain was found to be minor on the 13 night of the surgery in documented medical records. 14 Which medical records do you base this opinion on? 15 A. The Stateville medical records, the nurse's 16 note. 17 Q. For a particular date? 18 A. It was 10/19/2010, 3:50 p.m., signed by an 19 R.N., states pain is a 5 on a scale of 1 to 10. 20 Q. And so you described a pain of 5 out of 10 as 21 minor? 22 A. Yes. 23 Q. Okay. 24 A. Minor to moderate, I guess.</p>	<p>1 BY MR. O'HARA: 2 Q. So would you say maybe his last dose was three 3 hours before he arrived back at Pontiac or three hours 4 before the medical note was written at Stateville? 5 MR. LOMBARDO: Objection. Form as to vague. 6 BY THE WITNESS: 7 A. So let's see. The one is 3:50 and the other 8 is 12:50. So, yeah, it sounds right. 9 Q. So at the time he rated his pain at 5 out of 10, he had been dosed three hours ago with narcotics; is 11 that correct? 12 A. Yes. 13 Q. Okay. You state that Tylenol 3 with codeine 14 is an appropriate method of managing patients with 15 moderate pain; is that right? 16 A. So forgive me. I just don't like the minor, 17 moderate, severe thing because it depends so much on 18 context. I guess that's probably a true statement; but 19 all of these things, it's -- you try what you think is 20 appropriate and see what happens kind of thing, but yes. 21 Q. Okay. In your opinion, is Tylenol 3 -- and, 22 again -- we are going to get into the minor-moderate, 23 thing -- but since we have to use the terms in the 24 report, I guess, is where we are -- is Tylenol 3</p>

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<p style="text-align: right;">Page 106</p> <p>1 appropriate for treating patients with only minor pain?</p> <p>2 A. Tylenol 3 -- so two Tylenol 3, which is the 3 equivalent of 10 of hydrocodone, is appropriate for pain 4 moderate, severe, minor too if they are lucid, I guess, 5 you know.</p> <p>6 Q. Okay.</p> <p>7 A. You just -- I'm sorry. I'm trying to be 8 responsive to what you are saying, but you just can't -- 9 it's just not how medicine is practiced. There's no 10 standard. You know, there's no objective standard for 11 pain. You can say the blood loss is X; but there's no 12 objective standard to say what's minor, moderate, 13 severe. But, yeah, I think what you said is okay.</p> <p>14 Q. Right. But doctors certainly choose their 15 dosage and what medicine they're prescribing based on a 16 sense of a range of the strength of pain, correct?</p> <p>17 A. Say that again.</p> <p>18 Q. The strength of pain, whether you describe it 19 as minor, moderate, or severe, is certainly relevant to 20 how doctors prescribe pain medication?</p> <p>21 A. A little bit, but mostly we prescribe it based 22 on the procedure too. So like an ACL reconstruction, 23 you would generally get more pain there than you would 24 after a scope. So you would say after this, you would</p>	<p style="text-align: right;">Page 108</p> <p>1 them -- And I tell them -- I reference Michael Jackson 2 and Elvis Presley. And I say that if you're -- I say if 3 you're -- if you are a little drowsy and you take this 4 stuff, you can have respiratory suppression and die. 5 And I tell all my patients this. Okay? I say -- So you 6 make sure when you are giving this to them -- and that's 7 why the 1 out of 10 stuff is a little tricky too, 8 because this is a subjective thing that a patient says 9 and you've got to put that in the context of what the 10 patient looked like. If a patient is slurring their 11 words and you say are you in pain, ah, yeah, it's really 12 bad, give them stuff. You know what I mean? So they 13 have to be lucid -- I'm sorry. I don't mean to be going 14 on endlessly, but it's just a complex thing.</p> <p>15 Q. Understood.</p> <p>16 And your patients have the option to take the 17 hydrocodone or use other methods including NSAIDs or ice 18 or nothing?</p> <p>19 A. Yeah, depends on the procedure. So NSAIDs for 20 a lot of what I do isn't appropriate for what I do if 21 you are repairing something, then NSAIDs can interfere 22 with healing. So If I'm doing an ACL or rotator cuff, I 23 don't give them NSAIDs because they can interfere with 24 healing. But for this, yeah, it would be okay.</p>
<p style="text-align: right;">Page 107</p> <p>1 likely give this versus that. But you run into big 2 trouble. That's why it's a bad idea to do it if you're 3 a physician if you start calling things minor, moderate, 4 severe. So one way, it's impossible to communicate with 5 each other. Do you know what I mean? I don't mean to 6 be overly fastidious about this; but you just kind of 7 know after a heart transplant, you know, they need this, 8 right? After getting their nails clipped, they might 9 need this. What you yourself I think are pointing out 10 here, what's minor, moderate, severe, it's a function of 11 context; it's a function of were you medicated. But you 12 just kind of try to give the appropriate drug for the 13 appropriate procedure.</p> <p>14 Q. And would you say it's fair that you try to be 15 responsive to the patient's need for the pain 16 medication?</p> <p>17 A. Yes.</p> <p>18 Q. And you described earlier, you prescribed 19 hydrocodone, but you offer them the option of not using 20 it?</p> <p>21 A. Absolutely. I tell them don't take the stuff 22 unless ice has not helped and you are in significant 23 pain. And even then take half and see what happens. 24 And I tell them a lot more than that too. And I tell</p>	<p style="text-align: right;">Page 109</p> <p>1 Q. Okay. How do physicians determine whether a 2 pain medication is effective for a particular patient?</p> <p>3 A. It's a combination of the -- it's a 4 combination of experience, the subjective, and the 5 objective. So we have an idea from experience what's 6 likely to be needed. And you know your patient a little 7 bit too. And, I mean, there's other contexts too. 8 People who are substance abusers or drinkers or whatever 9 you know are going to need more because they have these 10 enzymes that get geared up and they chew up pain 11 medicines.</p> <p>12 So part of it's the nature of the patient; 13 part of it is what we know from experience; part of it 14 is what the patient says; and part of it is just 15 objectively when, you know, you are like looking at the 16 person. What the patient says is significant. But, for 17 example, I never refill pain medicine over the phone. 18 If people say that they are having excess pain, come in 19 because, you see, the thing you want to do is get rid of 20 root causes, you know. If I have a knee patient that's 21 having a lot of pain after this, there's no way in heck 22 you should have a lot of pain after this. And if 23 patients tell me this -- and sometimes they do. I had 24 one not long ago who said he was in terrible pain. And</p>

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<p>Page 110</p> <p>1 I said, Come in, maybe there's something wrong. And so 2 we put those people on crutches and you take a little 3 weight off the leg and the pain goes away. You know 4 what I mean? So you deal with root causes, but just 5 jacking up the meds is not a good idea.</p> <p>6 Q. So going back to Mr. Burton, I suppose, in 7 that 24 hours following surgery, he continued to 8 complain of pain regularly in those 24 hours; isn't that 9 correct?</p> <p>10 A. Well, on the 20th there was a note. And I 11 think this is a quote from the nurse that says, No 12 complaints of pain or discomfort at this time. So that 13 was the next day.</p> <p>14 Q. So that was the next day; but from the 19th in 15 the afternoon when he was brought in through overnight 16 into the following morning, Mr. Burton continued to 17 complain of pain, correct?</p> <p>18 A. Well, I'm sure he had some pain. I'm sure he 19 had some pain. How much, I don't know. There's a note 20 from 3:00 a.m., that's the morning, you know, the night 21 of where it says patient, quote, slept good. So, I 22 mean, you could have pain and sleep. But slept good, 23 probably not a ton of pain, you know.</p> <p>24 Q. Mr. Burton received, I believe, seven doses of</p>	<p>Page 112</p> <p>1 have been left on Tylenol 3? Necessary is probably too 2 strong a word. I think it was appropriate. I think it 3 was a good idea. Would he absolutely have had to do 4 that? Could he have been left on Tylenol 3? Maybe. 5 Although necessary? Absolutely necessary, no. But 6 advisable maybe would be better.</p> <p>7 I think anytime you can get people off of 8 narcotics in general, (a). (B) someone who is taking 9 other psychoactive drugs, (b). And (c) -- Well, so I 10 think it was a good idea. Could he have been left on 11 T3s? Maybe.</p> <p>12 Q. And so you say that Dr. Ghosh substituted 13 Motrin. He prescribed it; is that correct?</p> <p>14 A. I think so. Yes, he did.</p> <p>15 MR. O'HARA: Let's skip the next one there and hand 16 me the one after.</p> <p>17 (WHEREUPON, the document was tendered 18 to Counsel.)</p> <p>19 BY MR. O'HARA:</p> <p>20 Q. I'm holding what I'm going to be marking as 21 Plaintiff's Exhibit 4. These are the medication 22 administration records taken from the IDOC records. 23 They have Bates stamps of IDOC28 and 36 and IDOC288 24 through 344.</p>
<p>Page 111</p> <p>1 Tylenol 3 with codeine under Dr. Ghosh; is that correct?</p> <p>2 A. I think that's right.</p> <p>3 Q. Now, if those medications were prescribed PRN, 4 wouldn't he have to request them to receive the dosage?</p> <p>5 A. Yes.</p> <p>6 Q. So the fact that he was given seven doses 7 reflects that he was regularly complaining of pain 8 during that time?</p> <p>9 A. Oh, yeah. I mean, every -- you would -- I do 10 have patients, by the way, that say they have no pain 11 after these, I really do after these. But most patients 12 have some pain for sure.</p> <p>13 Q. Okay. So as we know, when he was released 14 from the infirmary, Dr. Ghosh substituted Mr. Burton's 15 medication from Tylenol 3 with codeine to Motrin 16 400 milligrams. And Motrin is ibuprofen, correct?</p> <p>17 A. Yes.</p> <p>18 Q. And you said that this was a necessary and 19 appropriate downward modification of his pain medicines. 20 Is that your opinion?</p> <p>21 A. It was certainly appropriate. So is that your 22 question? Was it appropriate? Yes, it was appropriate.</p> <p>23 Q. Was it necessary?</p> <p>24 A. Was it necessary? I don't know. Could he</p>	<p>Page 113</p> <p>(WHEREUPON, a certain document was marked Plaintiff's Deposition Exhibit No. 4, for identification, as of 01/04/2018.)</p> <p>5 BY MR. O'HARA:</p> <p>6 Q. Are you familiar with these documents, 7 Dr. Prodromos?</p> <p>8 A. Well, am I familiar with them? I would be 9 lying if I said I could tell by looking at this I can 10 tell if it's one of the things I looked at before. But 11 if these are the medication records when he was there, 12 then I guess.</p> <p>13 Did you ask if I recognize them?</p> <p>14 Q. Are these the documents you reviewed as part 15 of your report?</p> <p>16 A. Yes.</p> <p>17 Q. If you turn to the IDOC page 325, the Bates 18 stamps are in the far right corner.</p> <p>19 A. IDOC325?</p> <p>20 Q. Correct.</p> <p>21 A. Okay.</p> <p>22 Q. Do you see a handwritten note for Tylenol 3 23 dated 10/19/10?</p> <p>24 A. I see Tylenol 3. And -- right, so it was</p>

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<p style="text-align: right;">Page 114</p> <p>1 written and crossed out. That's what you're talking 2 about?</p> <p>3 Q. Yes.</p> <p>4 A. Yes.</p> <p>5 Q. So for someone who's not as familiar with 6 medical shorthand, can you describe that, kind of, bar 7 running across and what it's saying?</p> <p>8 A. I have to tell you, I'm not either.</p> <p>9 Q. Okay. Fair enough.</p> <p>10 A. I don't do these. The nurses and anesthesia 11 people do them. But it looks like it's crossed out, 12 so...</p> <p>13 Q. So this medical administration record records 14 that he was given Tylenol number 3 on 10/19/10; is that 15 correct?</p> <p>16 A. Yes.</p> <p>17 Q. But nothing in the medical administration 18 records in these packets show that Mr. Burton received 19 Motrin or ibuprofen following his dismissal from the 20 infirmary following surgery; isn't that correct?</p> <p>21 A. So there's an order for ibuprofen PRN on 22 page 327 and there's a date that I can't read. Is it 23 20? The one below is -- I can't tell.</p> <p>24 Q. These are difficult to read. My belief is</p>	<p style="text-align: right;">Page 116</p> <p>1 what I'm saying.</p> <p>2 Q. Okay.</p> <p>3 A. Because I read a note in there someplace that 4 said he had ibuprofen available to him in his cell. Did 5 you read that? And I wasn't sure I knew what that 6 meant, honestly. So I read it was prescribed. And the 7 first day was pretty clear to me. After that, I'm not 8 sure that I know.</p> <p>9 So, I mean, if it was available in his cell, 10 then maybe it didn't have to be administered. But I 11 honestly don't know. So maybe you're right.</p> <p>12 Q. Okay. Also in your report -- Strike that.</p> <p>13 It's your belief that 400 milligrams of 14 ibuprofen is an extremely effective treatment for 15 acute postoperative pain?</p> <p>16 A. Not 400. 2400. 2400 of ibuprofen, which is 17 the daily dose, if indeed he got it, is the equivalent 18 of 10 of hydrocodone. So that would basically be two 19 Vicodin in a day. So for a second postoperative day for 20 what he had -- did I say 400? Maybe I should have 21 specified the full dose.</p> <p>22 Q. Well, we can say -- why don't we say 23 400 milligrams ibuprofen, what is that Q4H?</p> <p>24 A. It was 800. It was 400, two tablets, QH. So</p>
<p style="text-align: right;">Page 115</p> <p>1 that this page shows sometime between April and June, 2 possibly August 2010.</p> <p>3 A. Yeah. 420. So that's probably not relevant, 4 right? Yeah. So your question is: Is this something 5 showing that the patient got ibuprofen?</p> <p>6 Q. Yes. Is there anything in the medical 7 administration record showing that he received ibuprofen 8 following his dismissal from the infirmary?</p> <p>9 A. When was this dismissal?</p> <p>10 Q. October 20, 2010, the day after the surgery, 11 which is the date Ghosh prescribed the Motrin.</p> <p>12 A. So this record that I have is a record of 13 medications administered in the general population.</p> <p>14 Q. I believe it's both insofar as it includes the 15 Tylenol 3, which was only given to him in the infirmary.</p> <p>16 A. Yeah. So I -- So two things: Number one, I 17 don't see anything showing he was given ibuprofen; 18 number two, I have to tell you quite honestly I'm not -- 19 so maybe he didn't get anything. That could well be. 20 But I'm not really sure of what I'm looking at here. So 21 I don't know if this, in fact, is a record of everything 22 that he was given. And if it's not listed, then maybe 23 he didn't get it. And if that's what you are saying, 24 you are probably right. I don't know that to be true is</p>	<p style="text-align: right;">Page 117</p> <p>1 it's 800 three times a day, so that's 2400. So you are 2 reading from my thing here, right?</p> <p>3 Q. Yes.</p> <p>4 A. That part, that's what it says. So, yeah, 400 5 of ibuprofen a day, I think, should have been fine.</p> <p>6 Q. Okay. Would less than that amount of 7 ibuprofen have been proper?</p> <p>8 A. See, again, you just don't know. And even 9 ibuprofen -- you know, it's better than opioids, but 10 there was an issue in him later where he said he 11 couldn't take nonsteroidals too. So, you know, all 12 drugs are bad, basically. So it's -- nothing is 13 appropriate unless you have to have it. Like I said, 14 our go-to thing is we use partial weightbearing, ice. 15 And my patients swear by ice. My patients like their 16 ice better than their narcotics. So if you can get by 17 with him with very little done, get him partial 18 weightbearing with crutches and put ice on it and take 19 nothing, you are better off. If you can't, then you can 20 take ibuprofen. But at that point, I think that would 21 have been enough if he needed something more.</p> <p>22 Q. Could you estimate how many of your patients 23 start taking ibuprofen alone within one day of their 24 surgeries?</p>

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<p>1 A. So I don't use ibuprofen that way because so 2 much of my surgery is repairing things, although this 3 one is not. But I do have a fair number of patients go 4 to plain -- So I step down to Tylenol. We do ice and 5 then narcotic, if they need narcotic, and then Tylenol. 6 So we step down to Tylenol. And for this kind of 7 procedure, it's not uncommon.</p> <p>8 I mean, I will have a patient who will tell me 9 they took nothing or took one -- I couldn't give you 10 exact numbers, you know. But so this amount of 11 ibuprofen is a bigger amount of pain medicine because 12 ibuprofen is a little stronger than Tylenol.</p> <p>13 Q. Again, maybe you won't know this, but do you 14 know how many of your patients continue narcotic 15 medications for more than one day?</p> <p>16 A. It depends what kind of surgery. For bigger 17 stuff, most of them, for -- and, by the way, I don't do 18 too many scopes like this either because there was so 19 little done, but for minor scopes -- How many keep 20 narcotics for more than a day? A majority do.</p> <p>21 Q. Okay.</p> <p>22 A. But, again, you know, it's of the choices they 23 are giving. And they might take like one tablet a day, 24 which might be less than the ibuprofen, you know. And</p>	<p>1 A. Yeah, right. So the 2400 -- the 2 2200 milligrams that I posited -- so for a guy, his 3 size, maybe it should be 2800 or something.</p> <p>4 Q. Are you aware of any cases of, let's say, a 5 230-pound man suffering respiratory suppression while 6 taking the prescribed dose of Tylenol 3?</p> <p>7 A. No.</p> <p>8 Q. Do you know -- I know you are not an 9 anesthetist or anesthesiologist, but do you know if 10 Tylenol 3 has a greater, lesser, or same risk of 11 respiratory suppression as Norco?</p> <p>12 A. In equianalgesic doses, they are all pretty 13 much the same.</p> <p>14 Q. Okay.</p> <p>15 A. So the two T3s should be the same as one 16 hydrocodone 10.</p> <p>17 Q. Okay. You mentioned earlier Tramadol is not 18 considered an opioid --</p> <p>19 A. Uh-huh.</p> <p>20 Q. -- medication.</p> <p>21 A. Yes.</p> <p>22 Q. Can Tramadol cause respiratory suppression?</p> <p>23 A. Well, I think it could. It's an -- I mean, I 24 guess you would have to give a lot of it. It's a funny</p>
<p>1 some take more, you know, they do. Not all my patients 2 are pain-free.</p> <p>3 Q. Would you say there's a standard time frame 4 they continue to take it? I know you mentioned earlier 5 that many times they don't finish the whole bottle.</p> <p>6 A. There's absolutely no standard time frame. 7 And I will tell you -- and as you probably know -- 8 thinking has evolved greatly on this to the point -- To 9 tell you the truth, I'm considering not giving 10 hydrocodone at all because it's more -- the big patients 11 is something else, you know, but it's more than most of 12 my patients need. And I'm really fussy about narcotics 13 to begin with. I don't use any pediatrics drugs in my 14 practice for anything except for some of this after 15 surgery. So I think -- I don't want to throw stones, 16 but I think they are clearly -- let's just say that the 17 general usage of these is maybe more than I think it 18 needs to be.</p> <p>19 Q. Okay. Does the efficacy of ibuprofen depend 20 on the size of the patient, all things being equal?</p> <p>21 A. Sure.</p> <p>22 Q. Okay. So you would expect ibuprofen to be 23 less effective in a large man like Mr. Burton than a 24 smaller patient?</p>	<p>1 drug. I'm not an absolute expert in that; but, yeah, I 2 mean, they all could suppress respiration.</p> <p>3 Q. Okay. In your opinion, did Dr. Ghosh violate 4 the standard of care when he prescribed Mr. Burton a 5 month's worth of Tramadol in March 2010 for knee pain?</p> <p>6 A. Before the surgery?</p> <p>7 Q. Before the surgery.</p> <p>8 A. You know, I didn't look closely at that. I 9 don't think -- I need to see the context. How often was 10 it? 50 milligrams every four hours? Do you know?</p> <p>11 Q. I would have to pull up the record. Maybe we 12 can return to that question after a break if we have a 13 chance to look it up.</p> <p>14 A. Okay.</p> <p>15 Q. I'm going to quote from your -- this is Burton 16 page -- no -- Burton page 6, in the large paragraph 17 second from the bottom. In the middle, you see 18 "furthermore"?</p> <p>19 A. Uh-huh.</p> <p>20 Q. Furthermore, the high prescription strength 21 dose of ibuprofen he received is equivalent in analgesic 22 effect to a moderate dose of narcotics but without the 23 risk of death from respiratory suppression.</p> <p>24 What's the basis of your claim that</p>

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<p style="text-align: right;">Page 122</p> <p>1 400 milligrams of ibuprofen is a high prescription 2 strength dose?</p> <p>3 A. So, number one, why is it a prescription dose? 4 Because anything more than 200 is prescription. So you 5 can't get 400 -- they come in 4s, 6s, and 8s. They are 6 all prescription. So it's prescription. Why is it 7 high? Because he was prescribed six a day.</p> <p>8 Q. Gotcha.</p> <p>9 A. Two tablets, three times a day. The maximum, 10 by the way, maximum recommended for ibuprofen is 3200 11 milligrams. So it's not the most that you can 12 prescribe, but it's in that ballpark.</p> <p>13 Q. Now, can you identify any equianalgesic tables 14 demonstrating that a 400-milligram dose of ibuprofen is 15 equivalent to an analgesic effect of a moderate dose of 16 narcotics?</p> <p>17 A. I can find you a table -- I don't have it 18 right here -- that says that -- I got this from a table. 19 It's -- and these notes that you have of mine, all of 20 these are taken from the chart. There are two 21 italicized comments here that are my comments to myself 22 for this and one of them mentions the 2220. So it's 23 standard information. So 2220 is listed as the same as 24 10 of hydrocodone. And I could get you that. I think I</p>	<p style="text-align: right;">Page 124</p> <p>1 it would only diminish after time, but isn't aggravation 2 of pain possible following a knee arthroscopy?</p> <p>3 A. It is possible. But it's only possible and 4 always -- and I mentioned below, there's only two ways 5 that it can possibly happen. One is if he gets an 6 infection, which he clearly didn't. The other is if 7 your activity level is too great for that period. And I 8 see this with my patients, by the way. I see patients 9 who have virtually no pain after surgery and come in 10 and, wow, this is great, you know, and then a week later 11 they are hurting. And it's always because they are 12 doing too much. And I warn people. My point is, the 13 answer to that is that you are doing too much, get off 14 your leg, use crutches, that kind of thing, and then it 15 goes away, always, 100 percent, unless it's an 16 infection.</p> <p>17 Q. And you are aware, Doctor, that in an 18 incarcerated setting, a certain amount of movement for 19 most prisoners is essentially unavoidable?</p> <p>20 A. You can move. You just use crutches to take 21 some of the weight off. I'm not saying he should stay 22 in bed all day. He should not do that. What I'm saying 23 is that sometimes people feel pretty good, maybe better 24 than they expected, and then they overdo it. And</p>
<p style="text-align: right;">Page 123</p> <p>1 have a link someplace, but it's readily available.</p> <p>2 Q. We will make a request to have a copy of that 3 after the deposition.</p> <p>4 A. Sure.</p> <p>5 Q. Would any doctors disagree with the claim that 6 a 400-milligrams dose of ibuprofen is equivalent to a 7 moderate dose of narcotics?</p> <p>8 A. So, again -- I mean, again, the best way to 9 state these things is quantitatively. So I'm saying 10 moderate to be clear here. No doctor would disagree 11 that 2220 milligrams of ibuprofen -- so you said 400, 12 but it's not 400; it's 2400, basically, in this case. 13 So no doctor should disagree that 400 milligrams of 14 ibuprofen are equianalgesic to 10 of hydrocodone. It's 15 in black and white unless there's some super 16 sophisticated pharmacologist that could quibble at the 17 edges. But that's standard medical information.</p> <p>18 Q. Okay. You state that the decision to go to 19 Motrin was an excellent choice by Dr. Ghosh. And we are 20 on the same paragraph there on the bottom.</p> <p>21 From the time of this excellent clinical 22 decision made by Dr. Ghosh, Mr. Burton's pain would only 23 diminish over time. Records from Stateville indicate 24 that this is, in fact, what occurred. So you say that</p>	<p style="text-align: right;">Page 125</p> <p>1 overdoing it is relative. They are not running 2 marathons. Do you know what I mean? But the answer is 3 always that they are doing more than what's appropriate 4 for your knee. And the answer is always to use 5 protected weightbearing, you know, be on it less, that's 6 part of it, or use protected weightbearing when you're 7 on it. But the answer is never more pain medicines.</p> <p>8 Q. Whose responsibility is it to determine what 9 the appropriate amount of movement is for the knee 10 following surgery?</p> <p>11 A. Well, what one tells the patient is -- I think 12 in pretty much every case. I mean, I think every doctor 13 would do this -- is that you would tell the patient, 14 Your knee is going to be kind of sore; you have to take 15 it easy; and just don't push it through pain. The wrong 16 answer, which is out there too much, is, you know, if it 17 hurts, take more pain meds. That's always the wrong 18 answer and it gets everybody into trouble. The right 19 answer is you tell the patient you self-adjust -- you 20 should; I certainly do -- and I'm sure Dr. Ghosh did -- 21 you tell the patient -- it's kind of obvious, right? I 22 mean, don't do things that make it hurt.</p> <p>23 Q. And then you go on to say that after that, 24 Records from Stateville indicate that this is, in fact,</p>

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<p style="text-align: right;">Page 126</p> <p>1 what occurred, this is being a diminishment of pain.</p> <p>2 A. Right.</p> <p>3 Q. Which records in particular support that</p> <p>4 contention, that Mr. Burton's pain decreased over time?</p> <p>5 A. Yeah, I don't know. That's October. I didn't</p> <p>6 copy down absolutely everything. But I've got one from</p> <p>7 February 9th, which is three and a half months later, I</p> <p>8 believe, that says, No complaints of pain or discomfort.</p> <p>9 So that one.</p> <p>10 Q. So several months afterward?</p> <p>11 A. Yeah. And I don't know. Maybe I should have</p> <p>12 written more stuff down from the time in between.</p> <p>13 Q. You are not able to identify any records</p> <p>14 showing that he had diminished pain in the week</p> <p>15 following his surgery?</p> <p>16 A. I wouldn't say I'm not able to do it. I</p> <p>17 didn't focus on that because you just don't get</p> <p>18 increased pain unless you are overdoing or there's an</p> <p>19 infection. So, you know, to me most of this -- I looked</p> <p>20 at all the stuff long term kind of for context, you</p> <p>21 know. So I don't know. I guess I could look throughout</p> <p>22 records again.</p> <p>23 But to me the main issue here was what</p> <p>24 happened pretty much in that first time after surgery.</p>	<p style="text-align: right;">Page 128</p> <p>1 and then maybe a little while later, they put more</p> <p>2 weight on and they have pain. Well, in a case like</p> <p>3 that, maybe the scope didn't work, maybe they need</p> <p>4 something else. But the taking some weight off always.</p> <p>5 It sort of can't not work. And the only other thing</p> <p>6 that would be out there from my perspective is if I'm</p> <p>7 missing some remote diagnosis.</p> <p>8 I had one patient -- pretty unusual that I</p> <p>9 remember well -- that had this burning pain on their leg</p> <p>10 no matter what -- and it turned out -- and I had the</p> <p>11 patient come in, you know, and they had developed a</p> <p>12 sciatic herniated disc making the pain run down the leg.</p> <p>13 You know, so I always want to make sure I'm not missing</p> <p>14 something else. So I would bring the patient in and</p> <p>15 examine them.</p> <p>16 You can have pain in the knee from the hip.</p> <p>17 So I would examine the hip and say, Gosh, what am I</p> <p>18 missing here? Do you know what I mean? But otherwise</p> <p>19 it's just always a matter of weightbearing and people</p> <p>20 don't like to hear this because it's inconvenient.</p> <p>21 People would always rather get a drug, so you have to be</p> <p>22 very careful. And people will complain of pain and say</p> <p>23 they really want pills, but our responsibility is just</p> <p>24 not -- is to treat the root cause, you know. So it's</p>
<p style="text-align: right;">Page 127</p> <p>1 But I would be happy to go back and try to -- see --</p> <p>2 well...</p> <p>3 Q. So let's say you have a patient -- one of your</p> <p>4 patients has a similar surgery, is sent out, and they</p> <p>5 are complaining of pain, there's no infection, and so it</p> <p>6 would be your understanding that they were too active on</p> <p>7 the knee; is that correct?</p> <p>8 A. Yes.</p> <p>9 Q. What advice would you give them?</p> <p>10 A. I tell them -- I say, Be on it less, don't be</p> <p>11 walking around a lot, but don't stay in bed all day, you</p> <p>12 know. And we either get people crutches or a walker</p> <p>13 depending on how old they are. And I tell them, If you</p> <p>14 take some pain [sic] off of your leg, I will guarantee</p> <p>15 that 100 percent of your pain will immediately and</p> <p>16 permanently go away, and it does. I tell every patient</p> <p>17 that. And it never doesn't work.</p> <p>18 Q. Would there be other options, treatments that</p> <p>19 you're -- not even treatments -- other things they can</p> <p>20 do?</p> <p>21 A. Yeah. And let me be clear, if you take weight</p> <p>22 off, it always works. The real issue would be, you</p> <p>23 know, maybe you do a scope in an arthritic knee and they</p> <p>24 are having some pain and they have to take weight off</p>	<p style="text-align: right;">Page 129</p> <p>1 always weightbearing for something like this or ruling</p> <p>2 out other obscure diagnoses.</p> <p>3 Q. Could they use ice as well?</p> <p>4 A. Oh, yeah. And -- I'm sorry. Yeah, ice is a</p> <p>5 given. It's always ice. So yeah. I'm sorry. I should</p> <p>6 have said --</p> <p>7 Q. I just wanted to clarify.</p> <p>8 A. Yeah. It's always ice and weightbearing.</p> <p>9 Q. And your patients also have the option of the</p> <p>10 medication you prescribed them too?</p> <p>11 A. Yeah, they do. But it's a limited amount and,</p> <p>12 you know, I don't prescribe more absent very unusual</p> <p>13 circumstances. So, yeah, that's part of the spectrum,</p> <p>14 for sure.</p> <p>15 Q. Gotcha.</p> <p>16 So just to loop back, I guess, on that one</p> <p>17 question. When you say that Mr. Burton's pain</p> <p>18 diminished over time, you are referring to in the months</p> <p>19 following rather than the week immediately following the</p> <p>20 surgery?</p> <p>21 A. I don't know. I probably should have written</p> <p>22 more down. The only thing I've got documented here is</p> <p>23 the month following. I don't remember the whole medical</p> <p>24 record and I didn't document it beyond that. So that's</p>

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<p style="text-align: right;">Page 130</p> <p>1 the only thing that I could cite. I don't know.</p> <p>2 Q. Okay. Doctor, have you ever left sutures from 3 an arthroscopy in for 44 days?</p> <p>4 A. I don't think for 44 days. We -- Here and 5 there, I have had one or two that have been left in for 6 several weeks or the nurse just didn't see it kind of 7 thing.</p> <p>8 Q. In your opinion, does leaving sutures in for 9 44 days meet the standard of care?</p> <p>10 A. Well, here's the thing, leaving sutures in -- 11 they are inert. It doesn't cause pain and it doesn't do 12 harm. Does it meet the standard of care? I don't know. 13 You like to take them out and we do and most people do. 14 Sometimes people miss one here and there. So does it 15 meet the standard of care? Gosh, I don't know. It's a 16 funny word, you know, I mean, if it doesn't, it violates 17 it in an unimportant way.</p> <p>18 Q. But leaving sutures in for 44 days might 19 violate the standard of care?</p> <p>20 MR. LOMBARDO: Objection, form.</p> <p>21 BY THE WITNESS:</p> <p>22 A. So could I ask you to define what the standard 23 of care means?</p> <p>24 Q. I actually can't.</p>	<p style="text-align: right;">Page 132</p> <p>1 want -- it's really important to not be giving patients 2 things that can treat severe pain when severe pain ought 3 not to be part of their course. If they are having 4 severe pain, the answer is not to give them things that 5 could mask it; the answer is to tell them to come in or 6 to call or something. You know what I mean?</p> <p>7 Q. Uh-huh. Okay.</p> <p>8 Moving on. Right after that, you say, 9 Furthermore, Dr. Ghosh referred Plaintiff to physical 10 therapy at Stateville, which, according to the medical 11 records, alleviated Mr. Burton's symptoms and increased 12 the range of motion in his knee. In factoring his 13 follow-up evaluations at UIC, Dr. Chmell noted that 14 Mr. Burton was doing well after surgery.</p> <p>15 Do you know the length of time between when 16 Mr. Burton was referred to PT and when he received it?</p> <p>17 A. I don't think I can tell you exactly.</p> <p>18 Q. Does it sound correct that it was nearly six 19 months?</p> <p>20 A. As I recall, it was kind of a long time. I 21 recall him complaining -- Mr. Burton -- that it was 22 taking them forever. So it seems to me like it was a 23 while.</p> <p>24 Q. So in your opinion, the prescription of</p>
<p style="text-align: right;">Page 131</p> <p>1 A. You know, honestly, it just makes something 2 insignificant sound really bad to say that. You know 3 what I mean? So I don't know what to say. Is it best 4 practice? Should you try to take them out? Yes. Was 5 it kind of an error not to take them out? Yes. Is it a 6 good thing -- is it a bad thing to leave them in? Yes. 7 Is it a harmful thing to leave them in? No.</p> <p>8 Q. Okay. Let's see. Right at the end, at the 9 very bottom line on 6, you say, Hereupon his release 10 from the infirmary, Dr. Ghosh provided Plaintiff with 11 crutches, an immobilizing knee brace, and a permit for a 12 low bunk. And you said that this treatment included 13 medical apparatuses and other accommodations that were 14 effective in treating any symptoms of minor pain that 15 Mr. Burton may have been experiencing. Would -- You 16 don't opine that the use of crutches, a brace, and a low 17 bunk would be effective in treating moderate or severe 18 pain; is that correct?</p> <p>19 A. Let me see. Well, yeah. I didn't say it, 20 but -- I didn't say it because it wouldn't be something 21 that -- Let me put it this way: I didn't say it because 22 he wouldn't have severe pain unless something else had 23 happened. Like an infection. And in that case -- so to 24 be clear -- and this is an important point -- you don't</p>	<p style="text-align: right;">Page 133</p> <p>1 physical therapy didn't do anything to alleviate the 2 postsurgical pain in the weeks following surgery; is 3 that right?</p> <p>4 A. Yes. But you have to understand that we don't 5 start physical therapy -- So in here -- It was kind of 6 interesting, in here he does physical therapy and he 7 feels that physical therapy helped him. Right? I don't 8 prescribe -- First of all, I don't always prescribe 9 physical therapy at all for these things. Secondly, I 10 don't prescribe physical therapy in the first three 11 weeks because physical therapy actually induces pain. 12 So if you -- And not every doctor practices this way; 13 but, you know, you are sitting in a PT clinic. So I 14 employ physical therapists. But physical -- If you take 15 a knee that -- it gets inflamed from the arthroscopic 16 procedure. And if you take that knee and you start 17 doing physical therapy which involves bending and 18 strengthening and that kind of stuff, it tends to make 19 people sore. So I'm very careful to not do physical 20 therapy in the immediate postoperative period and just 21 let people leave it alone.</p> <p>22 Q. Okay. So if you do refer someone to physical 23 therapy, what's the standard time after surgery you 24 would want them to begin?</p>

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<p style="text-align: right;">Page 134</p> <p>1 MR. LOMBARDO: Objection. Form. Calls for 2 incomplete hypothetical.</p> <p>3 BY THE WITNESS:</p> <p>4 A. It depends on the procedure. For rotator cuff 5 repairs, I wait ten weeks because early therapy has been 6 associated with an increased risk of tears. For a 7 typical arthroscopic meniscectomy, I wait three.</p> <p>8 Q. Three weeks?</p> <p>9 A. Uh-huh.</p> <p>10 And I see them back and I make sure they are 11 quieted down. And if they are not -- usually they are, 12 you know. And if they are not quieted down -- they get 13 quite really quick, maybe two weeks, maybe three. And 14 if they are very inflamed, I could wait longer. But 15 usually three for something like this.</p> <p>16 Q. Gotcha.</p> <p>17 A. And by the way -- sorry -- I don't think 18 there's any -- so later on he was kind of stiff, you 19 know, and they did the physical therapy for motion, and 20 I think that was useful. In general, I don't think 21 there's any need for physical therapy at all after what 22 he had done, by the way.</p> <p>23 Q. Okay. One brief thing I just want to make 24 sure I'm understanding, you say, right at the end of</p>	<p style="text-align: right;">Page 136</p> <p>1 work on your brain. And while opioids, you know, work 2 on the pain center, they do more than that, and opioids 3 can make people loopy; they can make people do weird 4 things. And whenever you're -- In fact, I don't even 5 give people sleeping pills if they are on these things 6 because if you are taking one drug that works on your 7 brain and you take another drug that works on your 8 brain, the fact that he is taking the bipolar drugs to 9 begin with increases the -- then if you add opioids to 10 it, the chances of having a weird neurologic side effect 11 goes up because you are taking two -- the fact of being 12 loopy, being out of your head a little bit, that kind of 13 thing.</p> <p>14 So I wasn't talking about abuse like being a 15 drug addict. I was talking that using opioids in people 16 that are on psychoactive drugs. You see what I'm 17 saying?</p> <p>18 Q. Yes. That's really a helpful clarification.</p> <p>19 Thank you.</p> <p>20 Talking about opioids, you also mention later 21 on that the United States is in the midst of an opioid 22 epidemic, some of it fueled by excessive prescriptions 23 by medical practitioners. Dr. Ghosh is to be commended 24 for his excellent, appropriate, and judicious use of</p>
<p style="text-align: right;">Page 135</p> <p>1 that paragraph, the top one on 7, It should also be 2 pointed out that Mr. Burton's psychoactive drugs he was 3 taking during this time frame increased the risk of 4 using opioids even more and represent another reason for 5 avoiding a prolonged use by Mr. Burton.</p> <p>6 Is it your opinion that psychoactives -- 7 psychoactive drugs cause an increased risk of opioid 8 abuse or that patients taking psychoactive drugs are at 9 a higher risk of opioid abuse?</p> <p>10 Does that make sense?</p> <p>11 A. So let me just tell you, I think maybe the 12 sense that I was using this word is not what you are 13 taking from it. So you -- I think you just said 14 "abuse." Right?</p> <p>15 Q. I did.</p> <p>16 A. So I wasn't -- I didn't use the word "abuse." 17 I used the word "use." So what I was referring to there 18 was not the abuse potential. Psychiatrists can tell you 19 better than me. I mean, it probably does, actually. I 20 don't know. But what I was talking about was being on 21 psychoactive drugs increases the risk of using opioids 22 because of the aggregated side effects, that if you have 23 a drug -- and I don't know what he was taking for his 24 bipolar -- but if you are taking -- all of those drugs</p>	<p style="text-align: right;">Page 137</p> <p>1 opioid pain medicines for Mr. Burton. That's your 2 opinion, correct?</p> <p>3 A. Yes.</p> <p>4 Q. What is the risk of, I suppose, the relevance 5 of the opioid epidemic to Mr. Burton's treatment?</p> <p>6 A. One thing we didn't talk about here -- We 7 talked about respiratory suppression, which -- and 8 constipation, for example, which can get to be a big 9 problem. But the other thing is when you are on these 10 things for any length of time, like several days, you 11 get habituated to them. And you get -- not your fault, 12 you know, doctor gives them to you. And then when you 13 stop taking them, one of the things that happens is you 14 have trouble sleeping and other things. So it's yet 15 another reason to get people off of them. And I'm just 16 trying to point out here because I gather part of the 17 issue in this case is whether Dr. Ghosh acted 18 appropriately. And, as I said before, I commend him 19 because I'm just putting context -- maybe I didn't need 20 to do this. I hope it didn't sound preachy -- but that 21 we have got a real problem, and doctors who -- and it's 22 hard -- by the way, the path of least resistance of a 23 doctor is just to give people things. You know? And so 24 when you restrict people with drugs, you run this kind</p>

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<p style="text-align: right;">Page 138</p> <p>1 of risk, for example, you know, the patient gets upset 2 and they go after the doctor, one thing or another. 3 So he showed -- I think he did the right 4 thing. I think it's a difficult thing and he is sitting 5 there in a prison, you know, and these guys are probably 6 kind of intimidating. So I'm just trying to point out 7 that there's a larger concept to this whole thing that 8 having a foot soldier in the war on drugs like him who 9 has the guts to do the right thing is just important in 10 general.</p> <p>11 Q. So, as you said, it's sort of in general. 12 That was -- Your point of making that statement, was 13 that about opiates more broadly? You weren't claiming 14 that Mr. Burton was at any specifically increased risk 15 for opioid abuse?</p> <p>16 MR. LOMBARDO: Object to form.</p> <p>17 BY THE WITNESS:</p> <p>18 A. You mean as to your prior question?</p> <p>19 Q. Yes.</p> <p>20 A. I don't know. I think that he probably is, 21 but I didn't want to say that because I really don't 22 know. I really can't back it up.</p> <p>23 Q. There's nothing in the record to indicate 24 that, correct?</p>	<p style="text-align: right;">Page 140</p> <p>1 opioid drugs appropriate? 2 A. Well, you know, it's an individual thing. 3 There are different circumstances. It's appropriate 4 when there are not other drugs, non-opioids, that you 5 think are appropriate. I mean, it's appropriate in 6 hospice. Right? You know, that's one place, in a 7 controlled environment. In my world it's appropriate 8 for postoperative pain. And I don't know. You know, 9 maybe I should be using even less then. I don't 10 otherwise use them except in rare circumstances, you 11 know. I mean, I do here and there, but very little. 12 So, I mean, it's an individual case. Is 13 risk-benefit analysis, you know. And every patient 14 is -- I've had patients who have been drug addicts and 15 alcoholics who tell me after surgery, Doctor, I don't 16 want any of the stuff, you know. So maybe the pain will 17 be appropriate but the context isn't. So it's all 18 individual.</p> <p>19 Q. Okay. Is there any possibility that his prior 20 treatment -- We know he had, I think, a month's worth of 21 Tramadol in March and then perhaps Motrin regularly -- 22 I'd have to go back to the records to find out 23 exactly -- could that length of treatment affect his 24 pain perception or drug tolerance?</p>
<p style="text-align: right;">Page 139</p> <p>1 A. Yes. And not anything against Mr. Burton 2 either, you know; but, you know, people who are on one 3 form of medication and, you know, maybe being in that 4 environment, but I don't know. I don't know. But, no, 5 I wasn't -- I wasn't talking about him being at 6 increased risk.</p> <p>7 And like you asked earlier, are prisoners 8 different than other people. They are not. The only 9 reason I paused before is I was thinking about context, 10 like if they are in danger because another thing that 11 occurred to me is -- you know, and it happens here 12 too -- people will kill and rob -- I mean, Vicodin is, 13 like, I'm told, 25 bucks on the street to kids, you 14 know. So if you're -- if you're in possession -- so we 15 tell people to keep it secret. Right? If you are in 16 possession of -- and some are more abusable than 17 others -- of narcotics, you are at risk of being robbed 18 or worse because you are carrying contraband. You know? 19 So is that a bigger risk in there? You know, I don't 20 know.</p> <p>21 I don't mean to be saying too much, but I was 22 just talking about not him being any different than 23 anybody else.</p> <p>24 Q. Okay. In your opinion, when is the use of</p>	<p style="text-align: right;">Page 141</p> <p>1 A. Well, so there's this thing called the 2 cytochrome P450 enzymes in your liver. And when you 3 take a lot of liver-metabolized drugs, like enzymes will 4 get revved up and you need drugs. So like alcoholics, 5 alcohol uses this stuff. So alcoholics are notoriously 6 harder to treat for pain meds. I don't think 7 Tramadol -- I'm not sure, to tell you the truth. I 8 mean, Tramadol is not one of those drugs you usually 9 think of like this. I don't think so with ibuprofen 10 either. I mean, maybe. Maybe a little. I'm not enough 11 of an expert on pharmacology.</p> <p>12 The things we know and what's been studied is 13 that people who are given heavy-duty opioids like 14 hydrocodone beforehand -- there's studies on this -- if 15 you get people who are in pain before surgery, just get 16 people off the stuff because if they are taking 17 hydrocodone before the surgery, the hydrocodone is going 18 to be less effective and then you have to give more of 19 the stuff and then the risk goes up. Alcohol, we know. 20 Beyond that, there are things that part of the 21 common perception. I mean, maybe a smarter doctor than 22 me would know some others, but that's what we generally 23 think of. So I would sort of doubt it to answer your 24 question.</p>

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<p>1 Q. Gotcha.</p> <p>2 And right toward the end, the last part of</p> <p>3 your discussion, you say, Moreover, any complaints of</p> <p>4 problems after the first week after surgery are</p> <p>5 unrelated to his postoperative acute pain and it would</p> <p>6 not be clinically appropriate to treat any such symptoms</p> <p>7 with dangerous opioid medication; is that correct?</p> <p>8 A. Yes.</p> <p>9 Q. It's possible for postoperative acute pain to</p> <p>10 continue for up to a week?</p> <p>11 A. Yes. To some degree, I think it does.</p> <p>12 Q. Have you ever had patients experience</p> <p>13 postsurgical acute pain for more than a week?</p> <p>14 MR. LOMBARDO: Objection. Form.</p> <p>15 BY THE WITNESS:</p> <p>16 A. Yeah. It depends what it is. So people with</p> <p>17 ACL reconstruction -- and, again, there's pain and</p> <p>18 there's pain, you know. So postoperative -- so what</p> <p>19 I -- Yeah. So the idea is that after a procedure like</p> <p>20 this, I mean, so he would have an incisional tenderness.</p> <p>21 I mean, if you poked on it, you know, it would hurt and</p> <p>22 maybe have a little pain, but it should be minor. You</p> <p>23 know, my patients -- yeah, my ACL reconstructions have</p> <p>24 pain, most of them, not all of them. I mean, they have</p>	<p>Page 142</p> <p>1 A. I do not.</p> <p>2 Q. Okay. Are you familiar with his work in any</p> <p>3 way?</p> <p>4 A. I am not except from his operative note here.</p> <p>5 I don't otherwise know him.</p> <p>6 Q. You don't know him by reputation?</p> <p>7 A. I actually don't.</p> <p>8 Q. Okay. And then for Dr. Ghosh, have you ever</p> <p>9 met Dr. Ghosh?</p> <p>10 A. No.</p> <p>11 Q. Are you familiar at all with his work?</p> <p>12 A. I am not.</p> <p>13 Q. Are you familiar with his reputation?</p> <p>14 A. No.</p> <p>15 Q. Okay. I want to turn back about -- I know</p> <p>16 we've been discussing this some, but -- what your</p> <p>17 patients can do besides take more medicine if they are</p> <p>18 having pain postsurgery.</p> <p>19 A. So the idea is that pain occurs for a reason.</p> <p>20 I tell my patients that pain is your friend because it</p> <p>21 tells you that there's something wrong and what to do</p> <p>22 about it. So this is what I live by in my practice.</p> <p>23 And, you know, after surgery, they are going to have</p> <p>24 some pain and you give them some medications. But the</p>
<p>Page 143</p> <p>1 some pain, but it diminishes a lot. So my point with</p> <p>2 this was that after the first week if he is hurting a</p> <p>3 lot, it's not from the surgery.</p> <p>4 MR. O'HARA: Okay. I apologize. I'm going longer</p> <p>5 than I hoped. I could use five minutes just to rally up</p> <p>6 the last line of questioning for a last go if that's</p> <p>7 okay with you.</p> <p>8 MR. LOMBARDO: I have a very short follow-up.</p> <p>9 MR. O'HARA: Yeah. I do want to leave you some</p> <p>10 time for that.</p> <p>11 THE VIDEOGRAPHER: Off the record at 7:28 p.m.</p> <p>12 (WHEREUPON, a brief break</p> <p>13 was had.)</p> <p>14 THE VIDEOGRAPHER: Back on the record at 7:37 p.m.</p> <p>15 BY MR. O'HARA:</p> <p>16 Q. Dr. Prodromos, as you know, you are still</p> <p>17 under oath.</p> <p>18 A. Yes.</p> <p>19 Q. I just want to follow up on a few last points.</p> <p>20 We have discussed two other doctors really</p> <p>21 specifically during our conversation, Dr. Chmell and</p> <p>22 Dr. Ghosh. And you said you are sure Dr. Chmell is a</p> <p>23 good surgeon. Just curious, do you know Dr. Chmell at</p> <p>24 all?</p>	<p>Page 145</p> <p>1 best way to practice medicine is to focus on the causes</p> <p>2 of the pain and not the pain. So for lower extremity</p> <p>3 surgery, it's virtually always protected weightbearing.</p> <p>4 And, obviously -- and I will see people. If I get</p> <p>5 something saying I have a lot of pain, I will see them</p> <p>6 because maybe they are getting an infection. In</p> <p>7 32 years I've never had one after a scope, but could be</p> <p>8 the next one, right? So that's the thing. You want to</p> <p>9 focus on causes and you want to focus on biomechanical</p> <p>10 things and, you know, ice, coolness. You have to be</p> <p>11 careful not to ice the skin so you don't get an ice</p> <p>12 burn, and then medications judiciously.</p> <p>13 Q. And the medications could include the opioids</p> <p>14 that are prescribed or, say, Tylenol?</p> <p>15 A. Yes.</p> <p>16 Q. They could go to the store and buy</p> <p>17 over-the-counter medications?</p> <p>18 A. Yes. And I -- and Tylenol is -- yeah. And</p> <p>19 sometimes there are occasions where Tramadol, I'll give</p> <p>20 them, but usually not. Usually it's ice, a narcotic, or</p> <p>21 no narcotic, and Tylenol, and protective weightbearing.</p> <p>22 Q. And they have ice machines, typically, we</p> <p>23 assume?</p> <p>24 A. Yeah. It's a little chore to get the</p>

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<p>Page 146</p> <p>1 insurance company to pay for them, so we work very hard 2 to do that. And if not that, then just continuously 3 icing with ice packs.</p> <p>4 Q. And if the pain is not improving, they can 5 come and see you, correct?</p> <p>6 A. Correct. We insist on that. My staff all 7 knows. If they -- I just don't give them -- because I 8 might be missing something, you know? So I will see 9 them the same day. So yeah.</p> <p>10 Q. Okay. Great.</p> <p>11 Turning to your report, you didn't personally 12 meet with Mr. Burton at any point, did you?</p> <p>13 A. No.</p> <p>14 Q. You didn't perform an examination?</p> <p>15 A. No.</p> <p>16 Q. The report, in particular, did you personally 17 draft this report?</p> <p>18 A. That we have been reading?</p> <p>19 Q. The one we've been reading.</p> <p>20 A. Yes.</p> <p>21 Q. Okay. So I want to go back to your list of 22 opinions that we discussed at the beginning of our -- 23 toward the beginning of our conversation.</p> <p>24 A. Where is that?</p>	<p>Page 148</p> <p>1 physical therapy. So yeah. So that's pretty much it.</p> <p>2 Q. Okay. Great.</p> <p>3 On the second one, the arthroscopic knee</p> <p>4 surgery that Mr. Burton underwent is a minimally 5 invasive procedure and cannot be attributed to causing 6 Mr. Burton's significant pain. Is it fair to say that 7 that opinion is based on your experience as a surgeon?</p> <p>8 A. Can I tell you something?</p> <p>9 Q. Yes.</p> <p>10 A. There's one part about that opinion I don't 11 like in looking at it now. And is it based on my 12 experience? It is. But what I should have said there, 13 and maybe I meant to say, I don't know, but it says, And 14 cannot be attributed to causing significant pain. I 15 should have said severe pain because it does cause 16 significant pain. That's just my using the wrong word, 17 and I apologize. So if you put severe in there, that's 18 more of what I really wanted to say. But is it based on 19 my experience? It is based -- you know, it's kind of 20 like what it says at the top. It's my -- at this point 21 I have been doing this for so long, it's based on my 22 experience but it's based on my education, experience, 23 training, knowledge, all this kind of stuff.</p> <p>24 Q. And was it also based on your review of the</p>
<p>Page 147</p> <p>1 Q. That is on BUR5. Excuse me, BUR7.</p> <p>2 A. Yes.</p> <p>3 Q. So we -- I think I asked you a question about 4 what were the bases for your opinion and that started a 5 long conversation between us and we didn't quite -- I 6 didn't quite close off that discussion. And so I want 7 to ask you: As far as this broad opinion number 1 that 8 Ghosh and the medical staff complied with the standard 9 of care, you said because they adequately treated his 10 pain; is that correct?</p> <p>11 MR. LOMBARDO: Objection. Mischaracterizes his 12 previous testimony.</p> <p>13 BY THE WITNESS:</p> <p>14 A. Well, I mean, the sum and substance of what he 15 needed, right. He adequately -- and I think, as I said, 16 I think he went -- he made two changes in the 17 medication, which I don't think he had to do. So I 18 think, you know, from the Norco to the Tylenol 3 to the 19 ibuprofen, so that I thought was very good. The nurses 20 mentioned that they, you know, checked the wound and 21 cleaned it and covered it with Betadine. There wasn't a 22 heck of a lot else to do for those. And he got him 23 crutches; he got him the low bunk; prescribed the 24 physical therapy even though I think that -- well,</p>	<p>Page 149</p> <p>1 surgical notes?</p> <p>2 A. Yes. In this case it is, right, because of 3 the nature of the scope.</p> <p>4 Q. Any other bases for that opinion?</p> <p>5 A. No.</p> <p>6 Q. Okay. Thanks.</p> <p>7 Tylenol -- You say, Tylenol 3 is an 8 appropriate substitute for Norco in treating Mr. Burton 9 for any acute pain he may have been experiencing 10 immediately following the surgery.</p> <p>11 Again, could you briefly describe your bases 12 for that opinion? It could be your experience, 13 education, training, and knowledge.</p> <p>14 A. Yeah, it's all of that. It's kind of the 15 equianalgesic doses that the Tylenol 3 -- so the two 16 Tylenol 3s have as much narcotic as 10 of the 17 hydrocodone. Actually, the reason -- I was thinking 18 about this: Why don't people use Tylenol 3 like they 19 used to? And, actually, the reason is, I think, that I 20 think the 300 milligrams of Tylenol in it -- so the 21 thing is -- one of the things that limits the use of 22 these narcotics is acetaminophen -- which is Tylenol -- 23 toxicity. So it has a lower ratio of narcotic to 24 acetaminophen. So you couldn't push the narcotic as</p>

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1 much because you would take too much Tylenol, although 2 for him it's fine because he wasn't needing a ton of 3 them.	1 A. Well, testify, that means court? 2 Q. No. At depositions. 3 A. Yeah. I get deposed for patients probably, I 4 don't know, six or seven a year, probably.
4 So I didn't mean to digress. Did I answer 5 your question?	5 Q. Would you say that you advocate on behalf of 6 your patients during these depositions? 7 A. Yeah.
6 Q. Sure. Well, let me just re-ask it or kind of 7 re-summarize it.	8 Q. Is it your understanding that your patients 9 are plaintiffs in personal injury lawsuits the reason 10 you are taking those depositions?
8 So your education, experience, training, and 9 knowledge, and this equianalgesic table in particular 10 were what you relied on to develop Opinion 3?	11 A. It's either personal injury or work comp. 12 Q. I would first like to draw your attention to 13 the medication administration record, which I believe 14 was Plaintiff's Exhibit 4. And I'm looking specifically 15 at IDOC327.
11 A. Yes.	16 Now, Doctor, you are not familiar with the 17 IDOC's medication administration record, are you?
12 Q. Anything else?	18 A. Not really.
13 A. No. Well, the medical record, you know, that 14 he wasn't in -- he shouldn't have been, but he wasn't in 15 horrible, severe pain.	19 Q. Do you have any understanding regarding 20 whether some pills are kept on the prisoner's person as 21 opposed to given on a watch-take basis?
16 MR. O'HARA: Gotcha.	22 A. The only hint I got from that, as I mentioned 23 before, is that somewhere in there there was a note that 24 said he had ibuprofen in his cell. So I don't know
17 That's it for me right now. If you do a short 18 direct, I would just reserve a minute or two.	
19 EXAMINATION	
20 BY MR. LOMBARDO:	
21 Q. Dr. Prodromos, you state in your report that 22 you have done thousands of knee surgeries, but I would 23 like to get a little more specific.	
24	
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1 (WHEREUPON, there was a brief 2 interruption.)	1 anything other than that. I don't really know what they 2 do specifically.
3 THE VIDEOGRAPHER: Back on the record at 7:47 p.m.	3 Q. In fact, I had informed you of that 4 information, that there's a difference between 5 watch-take medication and a medication that prisoners 6 kept in their cell.
4 BY MR. LOMBARDO:	7 A. Yeah.
5 Q. Dr. Prodromos, how many right knee 6 arthroscopies have you performed in your career?	8 Q. And I also advised you that ibuprofen is a 9 medication that's kept in the cell.
7 A. I don't know.	10 MR. O'HARA: Object to the form.
8 Q. Over 1,000?	11 BY THE WITNESS:
9 A. Yeah. I mean, I guess, yeah. I mean, do a 10 few hundred a year and I've been doing this for 11 30 years. So but -- So maybe it's a quarter of them, so 12 a thousand probably. I don't know if the right knee -- 13 the right knee is different than the left knee.	12 A. Yes.
14 Q. Have you done over 100 partial lateral 15 menisectomies in your career?	13 Q. Okay. Looking at IDOC327, while it's 14 difficult to appear, the third medication down, is that 15 ibuprofen 400 milligrams?
16 A. Yes.	16 A. Yes.
17 Q. Have you done over 100 chondroplasties in your 18 career?	17 Q. And what date does it appear that that 18 prescription ended?
19 A. Yes.	19 A. Well, it's written in there at 10/30/10, so 20 I'm assuming that's an accurate thing that's written in 21 there.
20 Q. Have you done over 100 procedures that involve 21 removal of loose bodies from the knee in your career?	22 Q. Assuming that's true, would Mr. Burton have 23 had his ibuprofen 400 prescription current through 24 October 30, 2010?
22 A. Yes.	
23 Q. I believe you testified that you often testify 24 as an independent treating physician.	

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1 A. Yes.	1 Q. I'm sorry. So you do have an opinion?
2 Q. And that would have been 11 days after	2 A. I do have an opinion that it did not.
3 surgery?	3 Q. That it did not...
4 A. Yes.	4 A. Impact his recovery after surgery.
5 Q. If my math is correct.	5 Q. I'm sorry. I lost you there.
6 A. Yes.	6 Would leaving in sutures for 44 days be
7 Q. The next exhibit I would like to show you is	7 attributed to pain in the knee after this type of
8 the UIC records, which are marked as Plaintiff's	8 surgery?
9 Exhibit 3. Dr. Prodromos, did you read Dr. Chmell's	9 A. No.
10 orthopedic notes in connection with forming your	10 Q. Do you have any opinions regarding the
11 opinions?	11 preoperative care provided to Mr. Burton?
12 A. I read his operative note. You mean his notes	12 A. Not really.
13 from before surgery?	13 Q. Were all of the opinions you gave today made
14 Q. Yes.	14 to a reasonable degree of medical certainty?
15 A. Not much.	15 A. Yes.
16 Q. How about immediately following surgery?	16 MR. LOMBARDO: That's all I have for now.
17 A. I honestly don't remember. I probably looked	17 MR. O'HARA: One minute.
18 at it, but I don't remember.	18 THE VIDEOGRAPHER: Off the record at 7:54 p.m.
19 Q. I'm going to direct your attention to UIC22.	19 (WHEREUPON, a recess was had.)
20 Could you please read the second, third, and forth	20 (WHEREUPON, the record was read
21 sentence of that section called History of Present	21 as requested.)
22 Illness?	22 THE VIDEOGRAPHER: Back on the record at 8:01 p.m.
23 A. He states that he has been doing well in the	23
24 interim but has a little bit of knee stiffness and some	24
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1 pain. He has been using crutches to assist with	1 EXAMINATION
2 ambulation. He states he has been able to put more	2 BY MR. O'HARA:
3 weight on the knee without discomfort.	3 Q. Dr. Prodromos, were you told to make any
4 Q. Okay. What is the date of that UIC note?	4 assumptions in drafting your report?
5 A. 10/25/2010.	5 A. No, I don't think so.
6 Q. So approximately how long is that after	6 Q. Okay. Turning to IDOC327, which I suspect
7 surgery?	7 Mr. Lombardo has handed to you. Mr. Lombardo, before we
8 A. Six days.	8 just had a brief break, made some representations to you
9 Q. What is your assessment of plaintiff's	9 about what prisoners may or may not be able to take
10 condition according to Dr. Chmell at that time?	10 medication in their cell. Do you recall that?
11 MR. O'HARA: Objection. Form and foundation.	11 A. Yes.
12 BY THE WITNESS:	12 Q. Your report contains no information about what
13 A. I mean, I think he is doing pretty well.	13 type of medication prisoners can take in or out of their
14 First of all, the doctor concluded that he is, quote,	14 cell; is that right?
15 doing well and he said he has a little bit of knee	15 A. Correct.
16 stiffness and pain. And presumably that would be --	16 Q. Okay. You have no opinion as to what
17 he's on ibuprofen and he says he was able to put more	17 medication prisoners may be able to take in or out of
18 weight on the knee without discomfort. So, yeah, he is	18 their cell?
19 doing pretty well.	19 A. Well, Mr. Lombardo just told me what -- some
20 Q. I want to go to the questioning about removal	20 things they can and can't, so I guess I have an opinion
21 of sutures. Do you have any opinion regarding leaving	21 now.
22 in the sutures for 44 days impacted Mr. Burton's	22 Q. But that opinion is not contained in your
23 recovery from surgery?	23 report?
24 A. I don't think it did.	24 A. No.

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<p>Page 158</p> <p>1 Q. Okay. And it's not based on the medical 2 records that you reviewed?</p> <p>3 A. Correct.</p> <p>4 Q. And it's not based on your personal knowledge 5 of the procedures at the prison?</p> <p>6 A. Correct.</p> <p>7 Q. Thank you.</p> <p>8 And, finally, if you take a look at that 9 middle entry on IDOC327 where it says ibuprofen, 10 400-milligram tablets, on the furthest left, there are a 11 series of dates. It looks like it may say, Original 12 order and discontinue, if you are able to read.</p> <p>13 A. Yes.</p> <p>14 Q. Counsel represented to you that the 15 discontinue date there was 10/30/10, I believe.</p> <p>16 A. Yes.</p> <p>17 Q. Are you able to read that line?</p> <p>18 A. Well, it's written over in pen.</p> <p>19 MR. LOMBARDO: Maybe you should look at the 20 original because I think I might have -- I will help 21 you.</p> <p>22 MR. O'HARA: We will object that he was shown an 23 exhibit with Counsel's writing on it.</p> <p>24 BY THE WITNESS:</p>	<p>Page 160</p> <p>1 STATE OF ILLINOIS) 2 COUNTY OF COOK) 3 I, KAREN ORENSTEIN, CSR No. 84-4693, a 4 Certified Shorthand Reporter of the State of Illinois, 5 and a Registered Professional Reporter, do hereby 6 certify: 7 That previous to the commencement of the 8 examination of the witness, the witness was duly sworn 9 to testify the whole truth concerning the matters 10 herein; 11 That the foregoing deposition transcript was 12 reported stenographically by me, was thereafter reduced 13 to typewriting under my personal direction and 14 constitutes a true record of the testimony given and the 15 proceedings had; 16 That the said deposition was taken before me 17 at the time and place specified; 18 That I am not a relative or employee or 19 attorney or counsel, nor a relative or employee of such 20 attorney or counsel for any of the parties hereto, nor 21 interested directly or indirectly in the outcome of this 22 action. 23 24</p> <p>Page 159</p> <p>1 A. So the first digit of the month is cut off. 2 The day looks like 20 and the year looks like 10. And I 3 can't tell what comes in front of it, honestly. And it 4 could be the day is 30 and the year is 10. And I can't 5 read the month. 6 MR. O'HARA: Okay. That's fair. I have no further 7 questions. 8 MR. LOMBARDO: Do you want to reserve signature or 9 waive? 10 THE WITNESS: Waive. 11 THE VIDEOGRAPHER: Off the record at 8:03 p.m. 12 (WHEREUPON, the following proceedings 13 were had off the video record:) 14 THE REPORTER: Do you need to order the transcript? 15 MR. O'HARA: Yes. E-tran. 16 THE REPORTER: Do you need a copy, sir? 17 MR. LOMBARDO: E-tran only, please. 18 FURTHER DEPONENT SAITH NOT. 19 20 21 22 23 24</p> <p>Page 161</p> <p>1 IN WITNESS WHEREOF, I do hereunto set my hand 2 at Chicago, Illinois, this 18th day of January, 2018. 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</p> <p><i>Karen Orenstein</i></p> <p>KAREN ORENSTEIN, CSR, RPR, CSR Certificate No. 84-4693</p>
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